



CHESPROCOTT HEALTH DISTRICT

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Kathryn Glendon, MPH, Director of Health

CHESPROCOTT HEALTH DISTRICT *Freedom of Information Act (FOIA) Request Form*

REQUESTOR INFORMATION

Name: _____ Phone: _____

Organization (if applicable): _____ Email: _____

Address: _____

REQUEST DETAILS

Pursuant to the Connecticut Freedom of Information Act (CGS §1-200 et seq.), I hereby request access to inspect or obtain copies of the following public records:

Description of Records Requested (please be as specific as possible):

Date Range of Requested Records (if applicable):

From: _____ To: _____

Preferred Format (select one):

- Electronic (email)
- Paper copies (fees may apply pursuant to CGS §1-212)
- Inspection only (on-site during regular business hours, CGS §1-210)

PURPOSE OF REQUEST (Optional)

Disclosure of the purpose of this request is not required under the Connecticut Freedom of Information Act.

ACKNOWLEDGMENT & SIGNATURE

Chesprocott Health District

I understand that access to certain records may be denied or redacted in accordance with exemptions under state or federal law, including but not limited to CGS §1-210(b). I further understand that fees may apply for copies or staff time as permitted by law.

Signature: _____

Date: _____

IMPORTANT NOTICE REGARDING ACTIVE CASES

Records related to active or ongoing public health investigations, inspections, or enforcement actions may not be immediately available for disclosure and may be exempt, in whole or in part, pursuant to the Connecticut Freedom of Information Act, including CGS §1-210(b), and other applicable laws.

All requests will be reviewed, and responsive records will be provided in accordance with state and federal requirements. Any non-disclosable information will be withheld or redacted as permitted by law.

FOR OFFICE USE ONLY

Date Received: _____

Approved Denied Additional Information Required

Notes: _____

Processed by: _____ Date: _____