ORLEANS COUNTY HEALTH DEPARTMENT

14016 Route 31 West, Suite 101, Albion, NY 14411
Phone (585) 589-3278
Fax (585) 589-2873
www.orleanscountyny.com/publichealth
Licensed Home Care Services Agency

Paul A. Pettit, MSL
Public Health Director

Brenden A. Bedard, MPH
Deputy Director

FOIL REQUEST

Date of Request _____

(Please Print)

Name of Applicant_____

Address_____

Representing_____

Daytime Telephone Number_____

I hereby apply to ☐ inspect and/or ☐ copy the following records:

_____

_____

_____

_____

_____

I understand the Records Access Officer must respond to my request within five business days of receipt of written request by making the records available or by denying access in writing giving the reasons for denial or providing a written acknowledgment of receipt of my request and a statement of the approximate date when the request will be granted.

I also understand and acknowledge that I will be charged a fee of $0.25 per photocopy for documents up to 9" by 14" and a fee of $1.00 for certification. Fees for copies of other records will be based upon the actual cost of reproduction. Payment must be made at the time copies of records are provided.

Signature of Applicant _____

Return completed application to:

Kimberly Castricone
Orleans County Health Department
14016 Route 31 West, Suite 101
Albion, NY 14411

For Agency Use Only:

☐ Approved

☐ Denied for reason(s) checked below

- ☐ confidential disclosure
- ☐ part of investigatory files
- ☐ unwarranted invasion of personal privacy
- ☐ record of which this agency is legal custodian cannot be found
- ☐ record is not maintained by this agency
- ☐ exempted by statute other than the Freedom of Information Act
- ☐ other (specify)

_____ _____ _____

signature title date

Receipt:

Number of Copies received: _____ Cost per copy: _____ Total amount due:_____

Cash/Check/Money Order received in the amount of $_____, on this date:_____

Make Checks/Money Order payable to: *Orleans County Health Department*

NOTICE: You have a right to appeal a denial of this application to the head of this agency, who must fully explain his reasons for such denial in writing seven days of receipt of an appeal.

I HEREBY APPEAL:

_____ _____

signature date