



Salt Lake Valley Health Department

**DIVISION OF ENVIRONMENTAL HEALTH**

Phone: (385)468-3860 Fax: (385)468-3861

**RECORD REQUEST**

(U.C.A. 63-2-204)

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Business Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Daytime phone number where you can be contacted if necessary: \_\_\_\_\_

**Address and description of records requested** (must provide reasonable amount of specific information):

\_\_\_\_\_  
\_\_\_\_\_

**Check appropriate request:**

- I would like to view/inspect the records.
- I would like to receive copies of the records. I understand that I will be responsible for copy costs. I authorize costs of up to \$\_\_\_\_\_. I understand that prepayment of copies over \$50.00 may be required; that I will be contacted if estimated costs are greater than the above-specified amount, and that there will be no response to this request for copies if I have not authorized adequate costs.
- I would like to receive copies of the records. I request a waiver of copy costs.  
*(Please attach information supporting your request; see U.C.A. 63-2-203(3).)*

**If the requested records are not public, please explain why you believe you are entitled to access:**

- I am requesting records that I believe to be public, that are classified otherwise. *(Present photo identification.)*
- I am the subject of the record. *(Present photo identification.)*
- I am the person who submitted the record. *(Present photo identification.)*
- I am authorized to have access by the subject of the record or by the person who submitted the record. *(Attach notarized "Consent For Release of Information" form.)*
- I am requesting expedited response that will be of benefit to the public rather than a person. *(Attach information that shows your status as a member of the media and a statement that the records are required for a story for broadcast or publication; or attach other information that demonstrates that you are entitled to expedited response under U.C.A. 63-2-204(3).)*
- I am otherwise authorized access. *(Attach documentation.)*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

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- I hereby acknowledge that I am a ( ) physician, ( ) psychologist, or ( ) certified social worker and that I will not disclose controlled information to any person including the subject of the record.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*