



Salt Lake Valley Health Department

DIVISION OF ADMINISTRATION

Phone: (801) 468-2717 Fax: (801) 468-2748

GRAMA – RECORD REQUEST

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

Name of Requestor: _____

Business Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime phone number where you can be contacted if necessary: _____

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