MACOMB COUNTY COMMUNITY MENTAL HEALTH

INFORMATION REQUEST
FREEDOM OF INFORMATION ACT

Date Requested:_____

Name: _____

Address: _____

City/State/Zip: _____

Information Requested: _____

_____

_____

To be completed by the MCCMH Deputy Director:

□ A deposit of $_____ (one-half of the estimated copying fee of $_____) was requested at the time the request was made and paid.

□ A deposit of $_____ (one-half of the estimated copying fee of $_____) was requested at the time the request was made but not paid.

□ I authorize the release of the requested information subject to the payment of fees, if applicable, as provided in County policy.

□ I recommend the denial of □ all of □ part of (choose one) this request for the following reason(s):

_____

_____

_____

_____ _____

Date Supervisor

□ This request for information is hereby denied as recommended.

□ The recommendation of the Program Supervisor is hereby modified as follows:

_____

_____

_____

_____ _____

Date Executive Director

Information Request, (rev. 4/11) MCCMH MCO Policy 10-012, Exhibit C