MACOMB COUNTY COMMUNITY MENTAL HEALTH

INFORMATION REQUEST LOG
FREEDOM OF INFORMATION ACT

Program _____
Date Requested _____ Date of Response _____
Name _____ Fee Charged _____
Address _____ Deposit Paid _____ Receipt #_____
City/State/Zip _____ Balance Due _____ Receipt #_____
Information Requested _____
_____
_____

Granted: □ in-whole □ in-part □ denied □ Check if explanation of denial attached

Program _____
Date Requested _____ Date of Response _____
Name _____ Fee Charged _____
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City/State/Zip _____ Balance Due _____ Receipt # _____
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Granted: □ in-whole □ in-part □ denied □ Check if explanation of denial attached

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