



CITY of
TRAVERSE CITY

Michigan Freedom of Information Act- Request for Public Records

If you are requesting any records that may contain protected health information, or HIPAA information, please complete the form on the next page titled, "City of Traverse City Request for Access to Health Information."

Name of Requester: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Contact Phone Number: _____ Contact Email: _____

Is this request on your behalf? _____

If no, on whose behalf is the request made? _____

Please note: Per MCL 15.233 (1), a requester must include the complete name, current and valid address, and current valid telephone number or electronic mail address for themselves if requesting on their own behalf. If requesting for another party, the information for that party is required. Address must be written in compliance with USPS addressing standards.

1. Please state the name of the public record you are requesting and include the following:

Names Referred to in Record: _____

Date of Record: _____

Location of Record, if known: _____

Other information helpful to identify the record:

2. Method of Access Desired: Pickup Mail Examine Email

Signature of Requester: _____

Date: _____

Return to City Clerk
Benjamin C. Marentette, MMC
City Clerk/FOIA Coordinator
400 Boardman Ave
Traverse City, MI 49684
231.922.4480
tcclerk@traversecitymi.gov



CITY OF TRAVERSE CITY
REQUEST FOR ACCESS TO HEALTH INFORMATION

I, _____, whose date of birth is _____,

request to **inspect** or **copy** (circle one) the following health information about

_____ contained in the City's records: _____

I understand that the City has 30 days to comply with my request and that it may in limited circumstances deny my request and, in the event that the City denies my request, the City shall provide me with an explanation in writing. If I do not agree with the denial, I may ask to have it reviewed by a person other than the person denying my request. I further understand that the City may charge a reasonable fee for the costs of copying, mailing or other supplies associated with my request, as allowed by law.

Dated: _____

Signature

Address: _____

Tel. No.: _____

I _____ personally observed _____ sign this document before me, a notary public on the following date: _____.

Signature of Notary Public

My Commission Expires

Name of Notary Public

* * RETURN TO PRIVACY OFFICIAL * *
CITY CLERK
CITY OF TRAVERSE CITY
400 BOARDMAN AVENUE
TRAVERSE CITY, MI 49684

A Government issued ID may be necessary.

FOR OFFICIAL USE ONLY

Date Received:

Action Taken (circle one): Granted Denied

Fee charged:

Reason for Denial (attach additional sheets if necessary):

k:\tcclerk\hipaa\form_requestforaccesstohealthinfo