Region XIII Gulf Coast Mental Health Center
1600 Broad Avenue
Gulfport, MS 39501

PUBLIC RECORDS REQUEST

DATE REQUESTED:____

REQUEST BY:____

ORGANIZATION:____

PHONE:____

ADDRESS:____
____
____

EMAIL ADDRESS:____

RECORDS REQUESTED

DATE RANGE (if applicable):____

DESCRIPTION OF RECORDS REQUESTED:____________________________
____
____
____
____
____
____

PREFERRED RESPONSE FORMAT:

MAP (Y/N)____

ELECTRONIC (Y/N)____

HARDCOPY (Y/N)____

DELIVERY METHOD ( ) Website ( ) Email ( ) Personal Pickup
( ) Overnight Mail ( ) First Class Mail

Fees must be paid by personal check or Money Order made payable to the GULF COAST MENTAL HEALTH CENTER

FOR INTERNAL USE ONLY:

Request Received Date: ________________

Request Received By: ________________

SUMMARY OF COST

Rate $ _____ * Hours _____ $_________

Data Size ___ mb * $10/mb $_________

Storage Retrieval Cost $_________

____ Copies * $0.25/copy $_________

TOTAL COST
OF REPRODUCTION $_________

Response Date: ________________

Response Prepared By: ________________

Records are unavailable as requested due to:
( ) Records are nonexistent
( ) Records are private data
( ) Production is cost prohibitive
( ) Other (See Attached Explanation)

YOUR SIGNATURE BELOW INDICATES YOUR APPROVAL AND AUTHORIZATION TO PROCEED WITH THE REPRODUCTION OF RECORDS AND YOUR AGREEMENT TO PAY ASSOCIATED FEES

Signature: ________________________________ Date:______________________