OPEN RECORDS REQUEST FORM

From:

Name: _____

Address: _____

_____

Telephone No. (_____) _____ (home) (_____) _____ (work)

(_____) _____ (fax)

To: CUSTODIAN OF RECORDS FOR SOMERVELL COUNTY HOSPITAL DISTRICT d/b/a GLEN ROSE MEDICAL CENTER

	Pursuant to V.T.C.A., Government Code, Section 551.001 et seq., I am requesting certain public records specifically:

	MADE AVAILABLE TO ME FOR EXAMINATION ONLY. I understand that if the documents are not readily available, the custodian may schedule a date and hour within a reasonable time for my examination of the documents. I understand that I must complete my examination within ten days of the date the records are made available to me.
	PHOTOCOPIED for my use where the information sought is in the form of paper.
	DUPLICATED for my use where the information sought is in the form of audiotapes, videotapes, computer tapes, or other similar recording systems

	MAILED to me at the address indicated below.
	FAXED to me at the number indicated above.
	PICKED UP by me or my representative at the Executive Director's Office, 1021 Holden Street, Glen Rose, TX 76043.

I agree to pay the costs of photocopying, duplication, the labor costs involved in retrieving information that is not readily available, and the cost of mailing or faxing. In the event the estimated labor costs exceed $40.00, an estimated labor cost will be provided prior to retrieval of the information.

I understand that the Hospital District may withhold information which is not considered public information under the Texas Open Records Act, accompanying Attorney General opinions, and case law. I also understand that the Hospital District is required to release only those documents that exist, in their current state, and that the Hospital District is not required to compile or create specific information or formats for my use.

_____

Signature Required