APPLICATION FOR PUBLIC ACCESS TO RECORDS
Suffolk County Department of Health Services

INSTRUCTIONS TO APPLICANT: Please complete Section I of this form. Do not leave any areas blank. Mail or fax a completed application to the Freedom of Information Officer listed below.

SECTION I: To be completed by Applicant.

Date of Application: ____________________________
Applicant Represents: __________________________
Applicant's Name (Please print): __________________________
Applicant's Mailing Address: __________________________
Applicant's Phone #: ____________________________
Applicant's Email: ____________________________
Applicant's Signature: ____________________________

I HEREBY APPLY TO:
☐ Inspect the following record
☐ Receive a copy of the following document(s)

(choose one box)

Describe the record sought and if in regard to a property include a complete tax map number (District, Section, Block & Lot in the proper format). Supply all relevant information that will help locate the record desired: date(s), a file title, reference number, the physical address, and property type (commercial/residential/subdivision). Complete one application for each address.

PROVIDE REQUEST TO: FOIL Officer
Suffolk County Department of Health Services
Post Office Box 9006
Great River, NY 11739-9006
Fax #: 631-854-0156

SECTION II - For use by Freedom of Information Officer (or designee) only

☐ Approved. Call to arrange an appointment to inspect the requested record.

Contact Person: ____________________________
Phone #: ____________________________

☐ Records not possessed or maintained by this agency.

☐ Records cannot be found after diligent search.

☐ Denied. Reason for denial: ____________________________

☐ Document(s) enclosed as requested.

☐ Receipt of this request is acknowledged. There will be a delay in supplying the requested record until payment of reproduction fee is received. The following fee applies $ ____________________________

☐ Other: ____________________________

Signature: ____________________________
Title: ____________________________
Date: ____________________________

Section III - Notice to applicant
You have the right to appeal a denial of this application in writing to the Office of the County Attorney within 30 days of the denial. Information as to the person to contact is shown below. The contacted person must respond to you in writing within ten business days of receipt of your appeal.

Suffolk County Attorney
H. Lee Dennison Bldg., 6th floor
100 Veterans Memorial Highway
Hauppauge, NY 11788
Business Telephone: (631) 853-4049