Public Records Request
Humboldt County Hospital District | Humboldt General Hospital

Date Request Received: _______________________________________ Time: _________________

Contact Information (the following information is for tracking and response purposes):

Name: ___________________________________________________________________________

Company Affiliation (if applicable): _____________________________________________________

Contact Address: ___________________________________________________________________
_________________________________________________________________________________

Telephone: _________________________________ Fax: __________________________________

Email: ____________________________________________________________________________

Signature: ________________________________________________________________________

Description of Records: ______________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Dates of Records: __________________________________________________________________
_________________________________________________________________________________

PENALTY FOR REMOVING, INJURING, OR CONCEALING PUBLIC RECORDS AND DOCUMENTS NRS 239.310 A PERSON WHO WILLFULLY AND UNLAWFULLY REMOVES, ALTERS, MUTILATES, DESTROYS, CONCEALS OR OBLITERATES A RECORD, MAP, BOOK, PAPER, DOCUMENT OR OTHER THING FILED OR DEPOSITED IN A PUBLIC OFFICE, OR WITH ANY PUBLIC OFFICER, BY AUTHORITY OF LAW, IS GUILTY OF A CATEGORY C FELONY AND SHALL BE PUNISHED AS PROVIDED IN NRS 193.130.
For Office Use Only

Method of Response:

_____ 5-Day Letter / Awaiting Response       Date: ________________________________

_____ Mail       Date: ______________________

_____ Fax       Date: ______________________

_____ Email     Date: ______________________

_____ CD       Date: ______________________

Public Inspection:   Yes _____    No _____

By Whom: _____________________________    Date: _________________________________

Amount of Fee Collected: _________________________________________________________

Notes: ________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Date Request File Closed: _________________________________________________________

By (Title): ______________________________________________________________________

www.hghospital.org/about-us/public-records-request/