Record/Invoice Number: _____

STATE OF CONNECTICUT
Office of Health Care Access
Freedom of Information
Request Form

Date: _____

Information being requested: (Please provide any and all specifics (i.e. Name of Facility, Docket Numbers, etc.) and specify which parts you would like copied (if photocopying is involved).

Return Request by: **(Please check one)** **Mail** ☑ ***Fax** ☐ **Pick Up** ☐
(*If available as paper copy for requests smaller than 20 pages.)

Please complete the following information:

_____
Contact Person Name

_____
Company

_____
Street Address

_____
Town, State and Zip Code

_____
Telephone **and** Fax Number

_____
Email Address

THE FOLLOWING IS TO BE FILLED OUT BY OHCA ONLY

Your bill for this service is:

Files on CD @ $5.00 per file	$
Paper Copies @ $.25/page	$
Other (Misc.) Items:	$
Postage & Shipping Charges (if any)	$
Total Amount Due	**$**

Payment: *AFTER YOU RECEIVE YOUR BILL, please make checks payable to "TREASURER, STATE OF CONNECTICUT" AND REMIT TO THE OFFICE OF HEALTH CARE ACCESS. 410 CAPITOL AVENUE, MS#13HCA, P.O.BOX 340308, HARTFORD, CT 06134 AS SOON AS POSSIBLE.*
PLEASE BE SURE TO INCLUDE ONE COPY OF THIS BILL WITH YOUR PAYMENT.

Note: *If the copying charge is estimated to be over $10.00, prepayment may be requested*

Revised July, 2005