



P.O. Box 281  
200 Hawthorne Dr.  
Nashville, IN 47448  
[bchealth@browncounty-in.gov](mailto:bchealth@browncounty-in.gov)

Health Officer- Michael Conway, MD

**Subject: Acknowledgment of Public Records Request**

Dear \_\_\_\_\_,

This response acknowledges receipt of your public records **request submitted to the Brown County Health Department** on \_\_\_\_\_ pursuant to the Indiana Access to Public Records Act (APRA), Indiana Code 5-14-3.

Your request seeks access to the following records:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

BCHD is currently reviewing your request to determine whether the records you seek are available for disclosure under APRA and whether any exemptions may apply. Some records may require additional time for retrieval, review, or redaction in accordance with state law and confidentiality provisions.

We will work to provide the requested records as soon as possible. If we determine that any part of your request cannot be fulfilled, or if an exemption applies to any portion of the records, we will notify you promptly in writing.

**Please note that if you request printed documents, you will be charged 10 cents for each black and white page.**

Access to public records will be provided during BCHD's regular business hours, Monday through Friday, excluding county holidays and emergency closures.

Thank you for your request and for your interest in the operations of the Brown County Health Department. If you have any questions or wish to clarify your request, you may contact us at (812) 988-2255 or via email at [bchealth@browncounty-in.gov](mailto:bchealth@browncounty-in.gov).

Sincerely,

Brown County Health Department



P.O. Box 281 200 Hawthorne Drive  
Nashville, IN 47448  
812-988-2255 - 812-988-5603 FAX  
www.in.gov/localhealth/browncounty  
bchealth@browncounty-in.gov

Health Officer: Michael Conway, M.D.

### Access to Public Records Act (APRA) Request for Public Documents Form

Please note that if you request printed copies of the records, you will be charged 10 cents for each black and white page.

Date:		Requester Name:		
Requester Firm/Organization (if applicable):				
Requester Address:		City:	State:	ZIP:
Requester Telephone Number (e.g. business, home, cell):		Requester E-mail Address:		
Please indicate the name and e-mail address or mailing address where the record(s) should be sent, if different from the requester above:				
Identify in detail each record(s)/document(s) that you are requesting with reasonable particularity so we can identify and locate them. Include dates, names, locations, document types, etc.)				
1.				
2.				
3.				
4.				
5.				
6.				

7.
8.
9.

**Preferred Delivery Method** (check one):

- Inspect the records in person (no fee for inspection)
- Copies (**paper or electronic; fees apply at 10¢ per page or actual cost**)
- Electronic delivery (if available)

**Acknowledgement & Signature**

I understand that while most records are public, certain records are confidential or discretionary under IC § 5-14-3-4. I also understand that the Health Department may charge a fee for copies as authorized by county ordinance.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Internal Use Only - Department Tracking	
<b>Date Received:</b> _____	