



BENEWAH COMMUNITY HOSPITAL
PUBLIC RECORDS REQUEST FORM

Date: _____

First Name: _____ Last Name: _____

Business Name/Affiliation: _____

Telephone: _____ E-Mail: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Description and date range of public records requested for disclosure (please include as much detail as possible so we can accurately respond to your request):

Idaho State Code § 74-120 exempts certain documents from public disclosure. If you have requested a document that cannot be disclosed, you will be notified. Use of any list as a mailing list or telephone list is prohibited by Idaho Code.

I certify that I will not use disclosed information for an illegal purpose. I also agree to reimburse Benewah Community Hospital according to the established fee schedule, if applicable:

Yes No

Signature of Requestor: _____

Send completed form to: E-Mail: rplante@bchmed.org

Fax: 208-245-2262

Mail: ATTN: Board Secretary
Benewah Community Hospital
229 S. 7th St.
St. Maries, ID 83861