PUBLIC RECORDS REQUEST

LANE COUNTY SHERIFF'S OFFICE
CORRECTIONS DIVISION

101 West 5th Avenue Eugene, Oregon 97401
Records Phone: (541) 682-2227 – FAX: (541) 682-2142

Section A – Requester Information

NAME OF REQUESTING INDIVIDUAL		RELATION TO OFFENDER
PHONE	FAX	E-MAIL
MAILING ADDRESS		
CITY	STATE	ZIP
SIGNATURE/DATE		

Section B – Information Request

OFFENDER NAME		AIRS NUMBER
DATE OF BIRTH	LODGING DATES	
DESCRIBE WHAT KINDS OF RECORDS YOU ARE REQUESTING:		
INTENDED USE OF RECORDS		

Please note: A separate consent form, signed by the inmate is needed to request medical documents. Lane County Adult Corrections staff shall locate and assemble the record(s) requested, eliminating any records which are exempt from disclosure (ORS 192.410 to 192.505).

Section C – Fee Schedule

Inmate File Request (per inmate/per lodging):	$10.00 first 4 pages, 25 cents for each additional page
Inmate History/Date of Incarceration Report:	$5.00 first 4 pages, 25 cents for each additional page
Inmate Arrest Report:	$5.00 first 4 pages, 25 cents for each additional page
Photo Only/Mug shot profile:	$7.00 per photo or mug shot profile
Special Research Requests:	Referred to Records Supervisor for coordination & cost estimate.

Please Note: Lane County Adult Corrections shall charge a reasonable fee for the location, assemblage, copying, and review of the records, as allowed under ORS 192.440.

Fee Schedule Effective: December 1, 2008

FOR CORRECTIONS PERSONNEL USE ONLY

Date request received:_____ by_____

Estimate	Request Status	Payment status
An estimate of $_____	□ Request prepared by _____	Amount received $_____
was provided on _____	□ Request Released by _____	□ Cash □ Check _____
by _____	□ Information not provided – law excludes information requested	□ Number of Pages _____

GENERAL CONSENT FORM

LANE COUNTY SHERIFF'S OFFICE
CORRECTIONS DIVISION
101 West 5th Avenue Eugene, Oregon 97401
Records Phone: (541) 682-2227 – FAX: (541) 682-2142

Authorization of Disclosure of Records

I, _____ authorize _____
NAME NAME OF PROGRAM TO DISCLOSE INFORMATION

to disclose to _____

_____

For the following purposes: _____

_____

I acknowledge that data which I am hereby authorizing to be released may include information that is specific to drug and/or alcohol and/or psychiatric treatment which cannot be released without my consent.

I understand that my consent to disclose may be revoked by me, at any time, except to the extent that action has been taken in reliance thereon.

This consent (unless expressly revoked earlier) will expire upon _____

_____.
SPECIFY DATE, EVENT, OR CONDITION UPON WHICH IT WILL EXPIRE

Signature of Client/Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Parent, Guardian,
or Legal Representative: _____ Date: _____

Specify Relationship: _____ Date: _____