



INFORMATION DISCLOSURE REQUEST
Minnesota Government Data Practices Act

OFFICE USE ONLY

Date of Request: _____ Request Received By: _____
Date of Completion: _____ Request Completed By: _____

Description of Information Requested:

Requestor's Name:

_____ Last _____ First _____ MI

Address:

Telephone:

Email:

Requestor's Signature:

***If mailed, return form and fees to:
IRRRB, P.O. Box 441, Eveleth, MN 55734**

OFFICE USE ONLY

Request Approved:

Request Denied:

If denied, please state reason below

Remarks/Comments:

Fees:

_____ X \$0.25 = _____ **If over 100 copies – employee time will be added**
of Pages Rate Total Fees

Employee Signature:
