



RECORDS REQUEST ORDER FORM

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| | DATE: |
| | FEES ATTACHED: CHECK NUMBER: |
| | COURT: CASE #: |
| ATTORNEY: | PLAINTIFF: |
| ATTENTION: | DEFENDANT: |
| FILE NO: | AUTHORIZATION <input type="checkbox"/> CLIENTS SUBPENA <input type="checkbox"/> ACS SUBPENA <input type="checkbox"/> |

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|--|--|---------------------------------|---|-----|--|
| PATIENT NAME: | | | | | |
| DESIRED RECORDS: | | | | | |
| MEDICAL RECORDS <input type="checkbox"/> | BILLING RECORDS <input type="checkbox"/> | X-RAYS <input type="checkbox"/> | OTHER - SEE ATTACHED <input type="checkbox"/> | | |
| DATE OF INJURY (IF APPLICABLE) | | DOB: | | SS# | |

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| (1) OPPOSING COUNSEL: |
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| ATTORNEY: |
| PHONE #: FAX #: |

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| (2) OPPOSING COUNSEL: |
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| ATTORNEY: |
| PHONE #: FAX #: |

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| (1) LOCATION OF RECORDS | |
| NAME: | CUSTODIAN OF RECORDS: |
| ADDRESS: | RECORDS DESIRED: |
| TELEPHONE: | |
| (2) LOCATION OF RECORDS | |
| NAME: | CUSTODIAN OF RECORDS: |
| ADDRESS: | RECORDS DESIRED: |
| TELEPHONE: | |