



**RECORDS REQUEST ORDER FORM**

	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"/>

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#	

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

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

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