

RECORD REQUEST FORM

Requesting Firm: _____
 Attorney: _____
 Claims Examiner: _____ Date: _____
 Secretary: _____ Phone: _____
 Address: _____
 City/State/Zip: _____
 Court: _____
 Case No.: _____
 Case Name: _____
 vs. _____
 Representing: _____
 File or Claim No.: _____
 Bill To: _____



2511 Garden Road
 Suite B100
 Monterey, California 93940
 Phone (831) 384-4030
 Fax (831) 384-4031
 www.SaylorLegal.com

Depo/Hearing Date: _____ DATE RECORDS NEEDED _____ PLEASE RUSH

PATIENT: _____ Date of Birth: _____ Social Security No.: _____ Date of Incident: _____ <input type="checkbox"/> Obtain any and all records <input type="checkbox"/> Prepare and submit records to court	PLEASE MARK APPROPRIATE BOX(ES) <input type="checkbox"/> Prepare Subpena <input type="checkbox"/> Subpena Attached <input type="checkbox"/> Authorization Attached <input type="checkbox"/> Obtain Medical Records <input type="checkbox"/> Obtain X-Rays <input type="checkbox"/> Obtain Billing Copy only records subsequent to: _____ <input type="checkbox"/> Provide additional set to requestor
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OPPOSING COUNSELS TO BE NOTIFIED: IMPORTANT TO INCLUDE ADDRESS, PHONE AND ZIP CODE

1.	2.
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SPECIAL INSTRUCTIONS/OMISSIONS

LIST UP TO SIX COPY LOCATIONS: IMPORTANT TO INCLUDE ADDRESS, PHONE AND ZIP CODE

1.	2.
3.	4.
5.	6.