

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 # _____
Bill To _____



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Fax (831) 384-4031
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Depo/Hearing Date _____ Date Records Needed _____ ☐ PLEASE RUSH

PATIENT _____
Date of Birth _____
Social Security # _____
Date of Incident _____

PLEASE MARK APPROPRIATE BOX(ES)

- | | |
|---|---|
| <input type="checkbox"/> Prepare Subpoena | <input type="checkbox"/> Obtain Medical Records |
| <input type="checkbox"/> Subpoena Attached | <input type="checkbox"/> Obtain X-Rays |
| <input type="checkbox"/> Authorization Attached | <input type="checkbox"/> Obtain Billing |

☐ Obtain any and all records

☐ Prepare and submit records to court

☐ Provide additional set to requestor

OPPOSING COUNSELS TO BE NOTIFIED — IMPORTANT TO INCLUDE ADDRESS, PHONE AND ZIP CODE

1.

2.

SPECIAL INSTRUCTIONS/OMISSIONS

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

1.

2.

3.

4.

5.

6.