

RECORDS REQUEST FORM



Phone 888-351-7331
 Fax 888-351-7058
 orders@equicopy.com
 customerservice@equicopy.com

Order Date: ____/____/____
 Please type or print clearly

Normal Service (ASAP) RUSH (specify date) _____

I. CUSTOMER / BILLING INFORMATION

Firm Name _____
 Attorney's Name _____
 Address _____

 Phone (____) _____ Fax (____) _____
 Firm File Number _____
 Contact Person (please print) _____

 Customer Signature _____

Send invoice to: Your Firm Carrier (complete data below)
 Carrier _____
 Adjuster's Name _____
 Address _____

 Phone (____) _____ Fax (____) _____

 Name of Insured _____
 Claim File Number _____
 Date of Loss _____

II. SUBPOENAS & AUTHORIZATION INFORMATION

Create Subpoena **Subpoena Attached** (attach proof of Notice)
 Superior Municipal WCAB
 Federal Arbitration
 Case Caption _____
 vs. _____
 Case Number _____
 Country _____ Judicial District _____
 Your firm represents:
 Plaintiff Defendant Other _____
 Name _____

Authorization Enclosed
 Opposing Counsel's Name _____ Esq.
 Firm _____
 Address _____

 Phone (____) _____ Fax (____) _____
 List of additional counsels attached
 Firm representing records subject:
 Your Firm Opposing Counsel Other Firm
 Name _____

III. RECORDS SUBJECT

Subject Name _____
 AKA _____

 Birth Date _____
 Social Security # _____

COPY INFORMATION

Total Number of Copies to: Your Firm Other
 Deliver Other Copies to: _____
 Transcribe Illegible Medical Records Prepare Narrative Summary
 X-ray Fee Limit? \$ _____

IV. RECORDS LOCATIONS Additional Locations Attached In Depth Research OK if required (additional cost) Records Type (listed below)

1. Location _____ Address _____ Phone (____) _____	<input type="checkbox"/> Copy Only These Dates <input type="checkbox"/> Copy All Records	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2. Location _____ Address _____ Phone (____) _____	<input type="checkbox"/> Copy Only These Dates <input type="checkbox"/> Copy All Records	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3. Location _____ Address _____ Phone (____) _____	<input type="checkbox"/> Copy Only These Dates <input type="checkbox"/> Copy All Records	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

If Necessary, Is Sub-Service of the Subpoenas OK? Hostile Service OK?

Record Types: A = ACADEMIC B = BILLING C = COURT FILES D = DENTAL E = EMPLOYMENT F = FINANCIAL G = ESCROW H = PHARMACY/PRESCRIPTION I = INSURANCE	J = PHYSICAL THERAPY K = WORKER'S COMPENSATION L = BLUEPRINTS M = MEDICAL P = PAYROLL	Q = AUTOPSY/DEATH R = PARAMEDICS S = SPECIAL REQUEST T = PATHOLOGICAL MATERIALS U = UNION	V = VIDEO TAPE W = SIGN SHEETS X = X-RAY/MRIS/CAT SCANS Y = PSYCHIATRIC Z = PHOTOGRAPHS	2 = PATHOLOGICAL REPORTS 3 = MRI'S ONLY 4 = CT SCANS ONLY 5 = FETAL MONITOR STRIPS
--	---	---	---	---

Additional Information/Instructions: _____

More Information/Instructions Attached

Send more: Records Request Forms Personal Appearance Forms
 Additional Location Forms Envelopes

Retain a Copy for your records. Thank you for choosing EquiCopy.