

# HG Litigation Services, L.P.

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## RECORDS REQUEST FORM

DATE ORDERED: _____	TRIAL DATE: _____
DATE NEEDED: _____	DEPO DATE: _____
CAUSE NO.: _____ COURT: _____	ORDERED BY: _____ TELEPHONE NO.: _____ FACSIMILE NO.: _____
COUNTY: _____	ATTORNEY FOR: DEFENDANT { } PLAINTIFF { }
STYLE OF CASE: _____	ORDERING ATTORNEY: _____  STATE BAR NO.: _____  LAW FIRM NAME & ADDRESS: _____ _____ _____
	REPRESENTS: _____

## RECORDS PERTAINING TO

LAST NAME: _____	FIRST : _____	MIDDLE: _____
DATE OF BIRTH: _____	SSN: _____	DATE OF DEATH: _____

## TYPE OF RECORDS

<input type="checkbox"/> EMPLOYMENT	<input type="checkbox"/> SOCIAL SECURITY
<input type="checkbox"/> INSURANCE	<input type="checkbox"/> UNION
<input type="checkbox"/> EDUCATION	<input type="checkbox"/> MEDICAL
<input type="checkbox"/> PAYROLL	<input type="checkbox"/> BILLING
<input type="checkbox"/> MILITARY	<input type="checkbox"/> PATHOLOGY
<input type="checkbox"/> I.R.S.	<input type="checkbox"/> REPORTS ONLY- <b>NO FILMS</b>
<input type="checkbox"/> OTHER RECORDS: _____	<input type="checkbox"/> FILMS- Indicate chest, back, head, arm, etc. _____
	Indicate which films are needed: <input type="checkbox"/> CXR <input type="checkbox"/> MRI <input type="checkbox"/> CT SCAN <input type="checkbox"/> ALL FILMS  If the doctor/hospital will not release original films, do you want copies? <input type="checkbox"/> YES <span style="margin-left: 200px;"><input type="checkbox"/> NO</span>

## INSTRUCTIONS

BY AFFIDAVIT WITH AUTHORIZATION- AUTHORIZATION ATTACHED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
BY AFFIDAVIT THROUGH SUBPEONA		
BY WRITTEN QUESTIONS- ADMISSABLE		
BY WRITTEN QUESTIONS- INADMISSABLE		

## ALL COUNSEL OF RECORD

ATTORNEY: _____	ATTORNEY: _____
LAW FIRM NAME & ADDRESS: _____ _____	LAW FIRM NAME & ADDRESS: _____ _____
REPRESENTS: _____	REPRESENTS: _____

## BILLING INFORMATION

## OTHER INSTRUCTIONS/ INFORMATION

SEND INVOICE TO: _____	
ADDRESS: _____	
CLAIM # / CLIENT MATTER #:	
ADJUSTOR: _____	

**RECORD LOCATIONS**

(Out of state subpoenas may require special handling and/or fees)

PATIENT NAME: \_\_\_\_\_

PROVIDER:	
ADDRESS:	
TELEPHONE:	
OTHER INFO:	

PROVIDER:	
ADDRESS:	
TELEPHONE:	
OTHER INFO:	

PROVIDER:	
ADDRESS:	
TELEPHONE:	
OTHER INFO:	

PROVIDER:	
ADDRESS:	
TELEPHONE:	
OTHER INFO:	