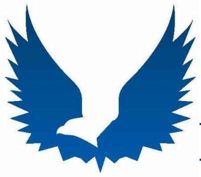


Los Angeles Records Service

10073 Valley View St., Ste. 221
Cypress, CA 90630
larecords@sbcglobal.net
Ph: 714-828-5679 Fx: 877-420-5573

Record Retrieval/ Litigation Support

RECORDS REQUEST

Date: ____________ Phone: ____________ Fax: ____________

Firm/Office: ____________ E-mail: ____________

Address: ____________ Ordered by: ____________

____________ Your File No.: ____________

Records Being Requested:

Records RE: ____________ Date of Injury: ____________

AKA: ____________ Date of Death (if deceased): ____________

Date of Birth: ____________ Medical Record No.: ____________

Social Security No.: ____________ Policy No./Group No.: ____________

Request Type:

☐ Rush? Order Type: ____________ / ____________

Authorization/Subpoena? Subpoena Type?

Delivery Preference: *(select all that apply)*

☐ Online ☐ CD ☐ Paper ☐ Bates-Stamp ☐ OCR Text Recognition ☐ Index w/Table of Contents (hospital only)

Need extra copies? How many? ________

Case Info (for subpoena only): *(you may attach a copy of the case caption in lieu of entering this information)*

Case title: ____________ Court Type: ____________

vs. ____________ Court Address: ____________

Court Case No.: ____________ ____________

County of: ____________ Attorney: ____________ SBN: ________

Insured/Client: ____________

Service List (for subpoena only): *(you may attach a copy of the service list in lieu of entering this information)*

Please type in Attorney Name, Firm, Address & Counsel

Attorney: ____________
Firm: ____________
Address: ____________
____
Attorney For: Plaintiff Defendant Other

Attorney: ____________
Firm: ____________
Address: ____________
____
Attorney For: Plaintiff Defendant Other

Attorney: ____________
Firm: ____________
Address: ____________
____
Attorney For: Plaintiff Defendant Other

Attorney: ____________
Firm: ____________
Address: ____________
____
Attorney For: Plaintiff Defendant Other

☐ Bill My Carrier?

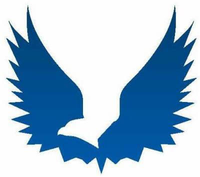
Carrier: ____________ Phone: ____________

Address: ____________ Adjuster: ____________

____________ Claim No.: ____________

Please Print a Copy For Your Own Records!

Next Page
Please Ô Ô



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LOCATION INFORMATION

Please enter the facility name, address (street, city, state, zip) and telephone (with area code)
Include the Records Type Codes (you may include more than one type) and date range of records being requested, if any

Record Type Codes: (M)-medical, (B)-billing, (X)-xray, (E)-employment, (I)-insurance, (S)-school, (P)-pathology slides, (Ph)-pharmacy, (A)-ambulance, (Mh)-mental health, (O)-other

Facility Name/Address/Phone	*Record Type Code(s)*	*Date Range, if any*
Facility: ______ Address: ______ ______ Phone #: ______	______	From: ______ To: ______ ☐ Any & all
Facility: ______ Address: ______ ______ Phone #: ______	______	From: ______ To: ______ ☐ Any & all
Facility: ______ Address: ______ ______ Phone #: ______	______	From: ______ To: ______ ☐ Any & all
Facility: ______ Address: ______ ______ Phone #: ______	______	From: ______ To: ______ ☐ Any & all
Facility: ______ Address: ______ ______ Phone #: ______	______	From: ______ To: ______ ☐ Any & all
Facility: ______ Address: ______ ______ Phone #: ______	______	From: ______ To: ______ ☐ Any & all
Facility: ______ Address: ______ ______ Phone #: ______	______	From: ______ To: ______ ☐ Any & all
Facility: ______ Address: ______ ______ Phone #: ______	______	From: ______ To: ______ ☐ Any & all

Other Instructions:

RE: