

REQUEST FOR RECORD RETRIEVAL

PLEASE COMPLETE THIS FORM TO INITIATE YOUR RECORD REQUEST.

刀

Ш

刀

Requesting Attorney:		Contact:	State Bo	ır #
Street Address:				
Phone: ()	Fax: ()			
E-mail:			_Represent	ting: Plaintiff Defendant
Opposing Counsel:				
Firm:			Contact	t:
Street Address:		City:		State:
Phone: ()	Fax: ()		Zip:	
E-mail:			_Represent	ting: Plaintiff O Defendant
Case Caption:		٧.		
CaseNo.:		Judge:		
Court:				
Records Pertain to:				
Date of Birth:	Social Sec	urity #:		
Deponent#1: Name:				RUSH (ADDL.FEE)
Address:	City/S	State/Zip:		
Phone No.:()	Authorization Attached Obtain from Opposing Counsel			
Specific Records Requested:				
Request Billing? O YES NO			Request	Radiology? O YES O NO
Deponent#2: Name:				RUSH (ADDL.FEE)
Address:				
	Authorization Attached Obtain from Opposing Counsel			
Specific Records Requested:				
Request Billing? O YES O NO				Radiology? O YES O NO
-			•	
Deponent#3: Name:				RUSH (ADDL.FEE)
Address:				
Phone No.:()				
Specific Records Requested:				
Request Billing? O YES O NO			Request	Radiology? O YES O NO
Date:	Siç	gnature of Reco	ords Custod	lian Notarized? O YES O NO
Bill Requesting AttorneyBill Direct to Insurer Name: Address:				aim#:

You must have **Acrobat Reader 8** or higher to complete this form online. You may also print and send via fax to 216.621.5444.

Please save this form to your computer for future use.