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CITY RECORD SERVICES

Records Request Form

info@sdcrs.com www.sdcrs.com
Phone: 619-201-8300 Fax: 619-201-8301
P.O. Box 191339 San Diego, CA 92159

1. Client Information

Order Date: ____ /____ /____ Needed By: ____ /____ /____

☐ Regular ☐ Rush ☐ Ordered by________________

Lawyer/ Adjuster ________________

Firm : ________________

Address: ________________

____

Claim No.________________ Phone: (_____)________________

2. Billing Information

Send Invoice To: ☐ Requesting Party ☐ Other (Please provide info. below)

Name ________________

Firm________________

Address: ________________

____

Phone: (_____)________________

Claim No. ________________

3. Copy Records Pertaining To

Name ________________

A.K.A. ________________

Birthdate____ /____ /____ Social Security No.______-______-______

Additional Info.________________

Date(s) of Loss or Injury: ________________

Total Number of copies:

Paper: ________________

CD: ________________

Deliver To: ☐ Requesting Party ☐ Doctor ☐ Attorney

Delivery Information Other than Requesting Party:

Location: ________________

Address: ________________

____

4. Release Information

Case Caption ________________

Versus ________________ ☐ Unassigned

Representing: ☐ Plantiff ☐ Defendant Case No. ________________

Court ________________ District ________________

Opposing Counsel ________________

Address: ________________

____

Contact ________________ Phone: (_____)________________

☐ Authorization Enclosed ☐ Application for Adjudication *or prepare:* ☐ W.C.A.B. S.D.T. ☐ Personal Appearance Date: ________

5. Obtain Records

Location: ________________

Address: ________________

________________Phone: (____)________________

☐ Medical ☐ Billing ☐ X-rays ☐ Employment ☐ Payroll

☐ Insurance: *Claim No.* ________________ *Date of Injury*____/____/____

☐ Other ________________

Location: ________________

Address: ________________

________________Phone: (____)________________

☐ Medical ☐ Billing ☐ X-rays ☐ Employment ☐ Payroll

☐ Insurance: *Claim No.* ________________ *Date of Injury*____/____/____

☐ Other ________________

Location: ________________

Address: ________________

________________Phone: (____)________________

☐ Medical ☐ Billing ☐ X-rays ☐ Employment ☐ Payroll

☐ Insurance: *Claim No.* ________________ *Date of Injury*____/____/____

☐ Other ________________

Location: ________________

Address: ________________

________________Phone: (____)________________

☐ Medical ☐ Billing ☐ X-rays ☐ Employment ☐ Payroll

☐ Insurance: *Claim No.* ________________ *Date of Injury*____/____/____

☐ Other ________________

Location: ________________

Address: ________________

________________Phone: (____)________________

☐ Medical ☐ Billing ☐ X-rays ☐ Employment ☐ Payroll

☐ Insurance: *Claim No.* ________________ *Date of Injury*____/____/____

☐ Other ________________

Location: ________________

Address: ________________

________________Phone: (____)________________

☐ Medical ☐ Billing ☐ X-rays ☐ Employment ☐ Payroll

☐ Insurance: *Claim No.* ________________ *Date of Injury*____/____/____

☐ Other ________________

☐ Additional Records Attached SEND MORE: ☐ Record Request Forms