P.O. Box 1676 • Modesto, CA 95353 • Phone: 209 549-8904 • Fax: 209 549-9328

Request for Services

PLAINTIFF(S) ____________________

DEFENDANT(S) ____________________

Requesting ____________________
Address ____________________

Telephone No. ____________________
Send invoice to ____________________
____
Ordered by ____________________

Type of Records

Via Authorization ____________________
Medical ____________________
Billing ____________________
Employment ____________________
Other ____________________

Via Subpoena ____________________
Civil Subpoena ____________________
WCAB Subpoena ____________________
Other ____________________
Case No. ____________________

Copy Instructions

No Omissions ________ Omit Nurses Notes ________ Omit Lab Reports ________
Omit Billing Records ________ Pick up Xrays: Copies ________ Original ________

In Reference To

Last Name ________ First Name ________ Middle Initial ________
Birth Date ________ SSN ________ Records From ________ To ________

Records From

____________________ ____________________
____________________ ____________________
____________________ ____________________

Parites of Records to be Served with Notice

Name(s)	Address(es)

By typing my name in the form field below, I/we herewith authorize DISCOVERY DATA REPRODUCTION SERVICES, LLC. to act as my/our representative for the purpose of procuring all records in accordance with the instructions contained in this order form.

By ____________________ Date ________ Due Date ________
Authorized Representative

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name:	Record Number:
Street Address:	Date of Birth:
City and State:	Social Security Number:
Zip Code:	Telephone:

1. I authorize the use or disclosure of the above-named individual's health information as described below: (See sections 2-8)

2. The following individual or organization is authorized to make the disclosure:

3. The type/amount of information to be used or disclosed is as follows (see dates where appropriate):

- o Immunization records
- o Behavioral Health records from (date):
- o Most recent summary
- o Laboratory results from (date): to (date):
- o X-ray and imaging reports from (date): to (date):
- o Consultation reports from (doctor name(s)):
- o Entire medical records from (date): to (date):
- o Entire itemized billing statements from (date): to (date):
- o Other: ____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Discovery Data Reproduction Services, LLC: PO Box 1676 Modesto, CA 95353
Phone: (209) 549-8904 Fax: (209) 549-9328

For the purpose of: **Patient's own personal use.**

6. **I have received a copy of this authorization**

7. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition**:** ____________ . If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

8. I understand that this authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand the recipient of this medical authorization may not condition treatment, payment, enrollment, or eligibility for benefits, on whether I sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient and may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management director or privacy officer for the above named health provider.

9. A copy of this Authorization shall be as valid and effective as the original.

___________________________ ___________________________

Signature of Patient or Guardian Date

___________________________ ___________________________

Printed Name of Signer Relationship to Patient
(self, parent, guardian etc.)

Click here to email process service instructions