



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

REQUEST FOR SERVICES

PLAINTIFF(S)

Requesting _____
Address _____

DEFENDANT(S)

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):

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