

QUEST DISCOVERY SERVICES

MAILING ADDRESS: P.O. BOX 49051, SAN JOSE, CA 95161-9051
 981 Ridder Park Drive, San Jose, CA 95131 (408) 441-7000 FAX (408) 441-7070
 4600 Roseville Rd Ste 200 North Highlands, CA 95660 (916) 483-7030 FAX (916) 483-7037
 3438 Mendocino Ave., Suite A, Santa Rosa, CA 95403 (707) 528-2300 FAX (707) 528-6047
 2507 West Shaw Ave., Suite 101, Fresno, CA 93711 (559) 224-0909 FAX (559) 224-1122
 20101 Hamilton Ave., Suite 210, Torrance, CA 90502 (310) 769-5557 FAX (310) 769-1466

- Subpoena for records, x-rays, etc. Subpoena with Autho.
- Authorization for records, x-rays, etc.
- Subpoena for Oral Depo: Appear only Appear with records
- reporter and: Video tape* Audio tape
- *Reserve the right to use video tape at trial, CCP 2025 (u)(4)
- Trial Subpoena: Appear only Records only Appear w/ records
- Pay witness fee/mileage at time of service: Yes No
- Depo/Trial Info.: Date: _____ Time: _____ Rm#: _____

PERSON ORDERING: _____ FOR: _____ ESO. BAR #: _____

DATE ORDERED: _____ NORMAL TIME: RUSH: SPECIFY DATE: _____ YOUR FILE _____

FIRM NAME: _____ ADDRESS: _____ CITY: _____ PHONE: _____ STATE & ZIP: _____ FAX: _____	FIRST AND LAST NAMES VS PLAINTIFF(S) DEFENDANT(S)
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REPRESENTING: PLTF. DFT. OTHER _____

FILED IN: SUP. MUNI USDC WCAB U.M. ARB. OTHER _____

COUNTY/DISTRICT: _____ CASE #: _____ INCIDENT DATE: _____

USE SPACE BELOW FOR DIRECT BILLING TO INSURANCE COMPANY

BILL TO: _____	NAME OF INSURED: _____
ADDRESS: _____	DATE OF LOSS: _____ CLAIM#: _____
CITY, STATE & ZIP: _____	ATTN: _____

RECORDS PERTAINING TO: GIVE ALL NAMES KNOWN BY

CCP 1985.3 (b) (1) If a minor, you MUST specify: age and address of minor and name and address of parent or guardian — California Civil Cases Only

IS THIS PERSON PARTY TO THE ACTION? YES NO

BIRTHDATE SOCIAL SECURITY # MEDICAL RECORD #

NAME _____	_____	_____	_____
AKA _____	_____	_____	_____
NAME _____	_____	_____	_____
AKA _____	_____	_____	_____

PLEASE USE CODES PROVIDED TO INDICATE TYPES OF RECORDS NEEDED

- | | | | |
|---|----------------------------|--------------------------------|------------------------------------|
| A - AMBULANCE (INCLUDE INCIDENT DATE) | I - MEDICAL INSURANCE | O - OTHER (ATTACH EXPLANATION) | X—X-RAYS/FILMS ONLY |
| B - BILLS ONLY | K - MEDICAL & PSYCHIATRIC | S - SCHOLASTIC | Y—PSYCHIATRIC |
| E - EMPLOYMENT (INDICATE TIME FRAME NEEDED) | M - MEDICAL | T - MEDICAL & BILLS | —MENTAL CONDITION MUST BE AT ISSUE |
| F - PHARMACY (INCLUDE RX #S) | N - MEDICAL & X-RAYS/FILMS | U - MEDICAL/X-RAY/BILLS | |

ENTER CODES:	NAME/ENTITY	ADDRESS(ES)	PHONE #	DO NOT USE
<input type="checkbox"/>	1. _____	_____	_____	
<input type="checkbox"/>	2. _____	_____	_____	
<input type="checkbox"/>	3. _____	_____	_____	
<input type="checkbox"/>	4. _____	_____	_____	
<input type="checkbox"/>	5. _____	_____	_____	
<input type="checkbox"/>	6. _____	_____	_____	
<input type="checkbox"/>	7. _____	_____	_____	

PARTIES TO NOTICE:

IF ADDITIONAL SPACE IS REQUIRED ATTACH SEPARATE SHEET

A. _____ Firm Name & Address	Attn: _____	Represents (Consumer Yes / No) _____
B. _____ Firm Name & Address	Attn: _____	Represents (Consumer Yes / No) _____
C. _____ Firm Name & Address	Attn: _____	Represents (Consumer Yes / No) _____

SPECIAL INSTRUCTIONS/OMISSIONS/# OF SETS: _____

SEND COPIES OF RECORDS/X-RAY FILMS TO: _____

- SEND MORE ORDER FORMS SEND MORE ENVELOPES