Complete all required (*) fields and return via:
Email: recordrequest@mm.services | Fax: 248-585-5822 | Mail: 3905 Rochester Rd, Royal Oak MI 48073

STEP 1 — NAME ON RECORD

Record Type *

☐ Individual ☐ Organization / Business

Last Name * | First Name * | Middle Name | Suffix

Date of Birth * | Also Known As / Maiden Name

Organization / Entity Name (complete only if 'Organization' selected above)

STEP 2 — CASE INFORMATION

Attach Case Caption (check if attaching instead of completing fields below)
☐ Yes — Case Caption attached

Notice of Intent (NOI — not yet filed)
☐ This is a Notice of Intent case

Case Name | Date of Incident / Accident

Claim / File / Case Number | Court / Jurisdiction

STEP 3 — RECORDS REQUESTED (CHECK ALL THAT APPLY)

☐ Medical Records (Complete)
☐ Medical Records (Itemized)
☐ Billing Records
☐ Radiology / Imaging & Reports
☐ Emergency Room Records
☐ Office / Clinic Notes
☐ Operative / Surgical Reports
☐ Pathology Reports
☐ Lab Results
☐ Physical Therapy Records
☐ Mental Health / Psychiatric Records
☐ Pharmacy / Prescription Records
☐ Death Certificate
☐ Workers' Compensation Records
☐ Employment / HR Records
☐ Other (specify below)

Itemized / Other — specify:

Preferred Delivery Method *

☐ Email (PDF) ☐ Secure Portal ☐ CD / Flash Drive ☐ Paper Copy ☐ Fax

STEP 4 — REQUESTING PARTY / ATTORNEY INFORMATION

Attorney Name *

Firm Name *

Contact Person *

Bar Number

Mailing Address *

City *

State

Zip

Phone *

Fax

Email *

Client / Matter Reference

Rush Request?

☐ Yes — Rush ■ Standard

STEP 5 — COUNSEL / CO-COUNSEL (IF APPLICABLE)

Counsel 1 — Attorney Name / Firm

Phone

Counsel 2 — Attorney Name / Firm

Phone

Counsel 3 — Attorney Name / Firm

Phone

Counsel 4 — Attorney Name / Firm

Phone

STEP 6 — BILLING INFORMATION

Bill To *

☐ Requesting Attorney / Firm (above) ☐ Third Party — complete below ☐ Client / Patient

Billing Contact / Company Name (if third party)

Billing Address

City

State

Zip

Billing Phone

Billing Email

Billing Fax

INSURANCE COMPANY / ADJUSTER (complete if billing insurance or sending copy to adjuster)

☐ Bill to Insurance Company ☐ Send Copy of Records to Adjuster

Adjuster Name

Insurance Company

Adjuster Address

City

State

Zip

Adjuster Phone

Adjuster Email

STEP 7 — DEPONENT(S) / WITNESS(ES) (IF APPLICABLE — UP TO 13 TOTAL, A–M)

A DEPONENT A

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

B DEPONENT B

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

C DEPONENT C

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

D DEPONENT D

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

E DEPONENT E

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

STEP 7 — DEPONENT(S) / WITNESS(ES) (CONTINUED)

F DEPONENT F

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

G DEPONENT G

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

H DEPONENT H

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

I DEPONENT I

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

J DEPONENT J

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

STEP 7 — DEPONENT(S) / WITNESS(ES) (CONTINUED)

K DEPONENT K

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

L DEPONENT L

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

M DEPONENT M

Deponent Type (e.g. Medical, Employment, Insurance, Legal)

Phone #

Deponent Name

Address

Requested Information

More than 13 deponents? Please complete an additional Record Request Form and reference the same file/case number.

STEP 7 — SPECIAL INSTRUCTIONS / NOTES

Additional instructions, specific page ranges, or notes for our team:

STEP 8 — CERTIFICATION & SIGNATURE

By signing below, I certify that the information provided is accurate and that I am authorized to request the above-described records. Minute Man Services, Inc. will process this request in accordance with applicable state and federal law, including HIPAA where applicable.

Signature (draw, type, or attach via Adobe Sign)

Sign here

Printed Name

Date

Title / Relationship to Patient (Record)

Bar Number (if Attorney)

IMPORTANT — AUTHORIZATION

A valid signed authorization may be required before records can be released. Minute Man Services will contact you if an authorization form is needed for your specific request type. If you have questions about authorization requirements, please call 248-585-6300 or email recordrequest@mm.services before submitting this form.

*** Required fields must be completed for processing. Incomplete requests may cause delays.**

Questions? Call 248-585-6300 or email recordrequest@mm.services — our team is here to help.