# HOSPITAL LIEN RECORD REQUEST FORM

## Requestor's Information:

Name: _____

Company: _____

Address: _____
Street City State Zip Code

Phone Number: _____ Fax Number: _____

Email Address: _____

## Requested Party Information:

Name: _____ Date of Birth: _____
First Middle Last

Hospital (If known): _____

Account(s) Number (If known): _____ Balance: _____

Please select one of the options below as verification of whether or not a hospital lien has been filed with reference to the above information.

1. _____ **YES**, a hospital lien has been filed by the above-named hospital in reference to the above-named party. Said lien was filed on _____. A copy of the lien is provided to the above-requestor.

2. _____ **NO**, a hospital lien has **NOT** been filed by the above-named hospital in reference to the above-named party.

Signature: _____ Date: _____
Putnam County Circuit Court Clerk

Print Name: _____