Medical Record Retrieval Order Form

LONE STAR LEGAL

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www.lonestarlegal.com

Job #: _____

Today's Date: _____

Due Date: _____ Time: _____

☐ Regular service (2-3 business days turnaround)

☐ 24-hour service

CUSTOMER INFORMATION:

Company: _____

Contact: _____

Phone: _____

Fax: _____

Email: _____

PO/Client Matter #: _____

☐ Address On File (pre-existing customer)

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

RETRIEVAL INFORMATION:

Location: _____

MRN: _____

Patient's Name: _____

Doctor has HIPPA/authorization? ☐ Yes ☐ No

Document(s) Requested/Research Instructions:

Include Exhibits?: ☐ Yes ☐ No

FINISHING/DELIVERABLE OPTIONS:

☐ Email / Cloud Upload

☐ CD with Label Number of disks needed: _____

☐ Print set Number of print sets needed: _____

☐ USPS Priority

☐ UPS Next Day/2nd Day/Ground, etc. _____

Customer's Account #: _____ ☐ Use Lone Star's UPS account
*charges will be added to invoice

Notes/Special Instructions: