THE CENTERS

Medical Record Retrieval Intake Form

Law Firm: **Contact Person & Phone Number:**		**Client/Case Name:** Age: **DOB:**
Date of Injury:	**Date Request Sent to CLS:**	**Type of Case:**
Brief Description Of Incident and Injury:		
Name of Pharmacy:		Was Your Client Seen at a Hospital: ☐ YES ☐ NO
Was Your Client Transported by Ambulance to the Hospital: ☐ YES ☐ NO		Executed HIPAA Included: ☐ YES ☐ NO

List of Treating Physicians/Providers:	**Records and/or Bills to Request:**	**Date(s) / Date Range to Request:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Required Fields are in **Bold*

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***If additional Treating Physicians/Providers are needed, please attach the additional list*