PREMIER RECORD RETRIEVAL

Authorization Order Form

Patient Information

First: _____

Middle: _____

Last: _____

DOB: _____

SSN: _____

Add'l Information: _____

_____

Please Attach Patient's HIPAA Authorization

Order Information

Ordered By: _____

Firm: _____

Email: _____

Phone #: _____

☐ **With Affidavit** or ☐ **Records Only**
(Check One)

Please attach record locations requested, with the following information:

- Facility Name, Address
- Type of Records Requested (Medical, Billing, Diagnostic Imaging, etc.)
- Dates of Service Requested

Submit all order information & attachments to Mike@PremierRecordRetrieval.com