The Centers for Advanced Orthopaedics
Potomac Valley Orthopaedic Associates
INSTRUCTIONS FOR REQUESTING MEDICAL RECORDS

_____ **has retained a professional service to handle the duplication and transfer of medical records. The company performing these services is:**

Record Reproduction Services (RRS)
600 North Jackson Street
Suite 104
Media, PA 19063
Phone: 301-690-9090 Fax: 443-276-6608
mrr@rrsmedical.com

In order to standardize and expedite all requests for patient information, please follow the process below:

1. Sign, date, and completely fill out the **Medical Record Release of Information Authorization** provided to you. Please **include your phone number and complete address** on your request in the event there are any questions regarding the release of your records.

2. Submit your signed and COMPLETED **Medical Record Release of Information Authorization** to the above address, email it to mrr@rrsmedical , or fax it to 443-276-6608

3. There may be a fee for the transfer of your information. Please use the grid below to determine the correct amount:

Please check one	Transfer to Whom?	Record Type	Charge
☐	Physician	Chart	No Charge
☐	Patient	Electronic Delivery	$6.50

4. Records will be delivered by electronic delivery unless otherwise indicated on the **Medical Record Release of Information Authorization – PAPER RECORDS MAY HAVE AN ADDITIONAL FEE for Delivery .**

RECORDS ARE AVAILABLE VIA secure email Please clearly indicate your email below if you have any questions please contact RRS @ 301-690-9090

_____ **@** _____ **.** _____

In order for your request to be processed, please be sure to fill out all fields on the medical records release form. Your request may be delayed if RRS cannot determine:

- **Who you are – Your name, DOB, and address**
- **What records need to be sent – What records, specifically the dates of service or body parts examined**
- **Where you would like the records sent – Complete address of where the records are to be delivered, in addition to a fax number if you would like them to be faxed**
- **Your signature and when you signed the Medical Record Release of Information Authorization – You must sign and date the form in order for it to be valid.**

Your request will be completed within 10 days of receipt of the request. If you request only the electronic portion of your chart, you may receive your information faster

If you would like, we can bill your credit card directly to avoid any bills being sent to you. Providing a payment upfront may significantly reduce turnaround times.

If you have any questions on the process or how to complete the form, please contact RRS - Addition resources are available

Record Reproduction Services (RRS)
600 North Jackson Street
Suite 104
Media, PA 19063
Phone: 301-690-9090 Fax: 443-276-6608
mrr@rrsmedical.com

Medical Record Release of Information Authorization

The Centers for Advanced Orthopaedics
Potomac Valley Orthopaedic Associates

Be sure to complete all fields so that you can be contacted with any issues that may arise. Failure to provide any of these fields will result in delays of the delivery of the medical information.

WHO

Patient Name: _____ Date of Birth: ___/___/_____ SSN #: (last 4)- _____

AKA or Maiden Names: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (___) _____-_____

Email: _____ @ _____ . _____ Fax: (___) _____-_____

WHERE

Doctor you would like information from

Doctor Or Facility Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____ Fax: (___) _____-_____

Where you would like info sent to

Please indicate all fields even if you would like the records faxed. Larger files cannot be faxed and RRS will need a complete mailing address

☐ Self

Doctor Or Facility Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____ Fax: (___) _____-_____

WHAT

In order to receive the fastest services please specify the information that is being requested. Larger files will take longer to process and deliver. Reducing requests to the minimum necessary allows RRS to provide the quickest turnaround times.

Dates of Service: - From: ___________ - To: ___________

Specific Information: _____

Records will be delivered BY ELECTRONIC DELIVERY unless otherwise indicated. Deliver on Paper: _____ Yes

WHY

Purpose of Disclosure - Please select one:

☐ Referral to Specialist ☐ Insurance ☐ Workman's Comp
☐ Legal Investigation ☐ Disability Determination/ Claim ☐ Personal
☐ Transfer of Care ☐ 2nd Opinion ☐ Other: _____

Legal Requirements

You MUST agree or disagree to each of the following. Please be advised that disagreeing to any of the following may result in portions of your medical file being withheld from the response

Unless otherwise revoked, this authorization will expire six months from the date from which it was originally signed or on the following date ___/___/_____

My evaluation, diagnosis, and/or treatment relating to the conditions listed below may be released to the requestor identified above for the following type of records unless otherwise indicated.

Agree ☐ Disagree ☐ N/A ☐ - AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
Agree ☐ Disagree ☐ N/A ☐ - Psychiatric care and/or psychological assessment
Agree ☐ Disagree ☐ N/A ☐ - Treatment for alcohol and/or drug abuse.
Agree ☐ Disagree ☐ N/A ☐ - Mental Health Treatment

Failure to complete this section will automatically imply a declination of the above

Signature

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure continued treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that there may be a fee for this service.

Requests cannot be processed without proper authorization. Minors must have a parent signature. Individuals requesting records on deceased or adult patients must provide the required Power of Attorney or other supporting legal documents.

_____ Date: _____

Signature of Patient or Authorized Representative