600 N. Jackson St, Suite 104
Media, PA 19063
P: 484.468.1299
F: 484.468.1247
mrr@rrsmedical.com

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS

PATIENT INFORMATION

Patient's Name	Maiden/Alias
Address	Date of Birth
Apt/Unit/Suite	Phone
City,State,ZIP	Email

RELEASE INFORMATION FROM

I authorize the release of information FROM:

Philadelphia Hand to Shoulder Center

RELEASE INFORMATION TO

I authorize the release of information TO:

Facility/Company/Person	Phone
Address	Fax #
City,State,ZIP	Email

DELIVERY METHOD

☐ Electronic Access (preferred) ☐ Fax ☐ Paper-USPS Mail ☐ CD-USPS Mail

Note: if electronic access is checked, an email will be sent from info@rrsmedical.com. Please make sure to check your bulk/spam boxes. If Imaging Films is checked in the box below, the default delivery method is CD-USPS Mail, unless otherwise specified.

PURPOSE OF RELEASE

☐ Continuing Care ☐ Transfer of Care ☐ Referral ☐ Personal
☐ Legal ☐ Insurance ☐ Disability ☐ Other _____

INFORMATION TO BE RELEASED

Dates of Service Requested: FROM _____/_____/_____ TO _____/_____/_____

☐ Entire Chart ☐ Office Notes ☐ Consults ☐ Lab Reports ☐ Radiology Reports
☐ Imaging Films ☐ Medications ☐ Immunizations ☐ Operative Reports ☐ Physical Therapy
☐ Itemized Billing ☐ Other _____

I authorize the release of information or references to the existence of and/or treatment for drug/alcohol abuse, mental health, sexually transmitted diseases, genetics, Hepatitis B or C, HIV/AIDS. This information will be released unless I indicate by checking below that I do not want such information released.

☐ DO NOT RELEASE

I authorize the disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request by written notification, but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider by whom this authorization is furnished may not condition their treatment of me on whether or not I sign the authorization. There may be a charge for your records; please have facility discuss pricing as indicated.

Signature: _____ Date: _____

Reason if patient is unable to sign: _____
(Provide guardianship, executor of estate, death certificate, or power of attorney paperwork with request)

Instructions for Requesting Medical Records

RRS Medical, a professional service, will handle the duplication and transfer of your medical records

Please follow the process below to expedite your request for patient information:

1. Sign, date, and completely fill out the **Medical Record Release of Information Authorization Form (Form)** provided to you. **Complete all fields and ensure your information is correct** so we may contact you with any questions.

2. **Submit your signed and fully completed Form** one of three ways: (1) mail to RRS Medical at the address below; (2) email to mrr@rrsmedical.com; or (3) fax to 484-468-1247.

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

Transfer to Whom?	Record Type	Charge
Physician	Chart	No Charge
Patient	Chart w/ Electronic Delivery (Email or Fax)	$6.50
Patient	Chart w/ Paper Delivery (US Mail)	$6.50 + shipping
Attorney, Insurance, 3rd Party	Chart (Paper or Electronic Delivery)	Varies by state

Paper Copies May Have An Additional Fee If Requiring Faster Delivery

4. **Records will be provided through e-Access (on-line Portal); fax; or US Mail.** Your request will be completed within 10 days of receipt of the request. Records will be delivered electronically unless otherwise indicated on the Form.

E-ACCESS PORTAL	e-Access is the fastest way to receive medical records • Emails will be sent from Info@RRS Medical.com • You will receive an email with instructions and a link for payment • Once paid, Login credentials & instructions to download records will be emailed to you *Check your Spam folder if the emails are not in your In-box after 3 days of the request
FAX	• Records faxed to a physician or provider's office will be sent directly to them at no charge • Records faxed to you/the patient will be sent directly to you and will include an invoice • Records faxed to a third party will receive an invoice for pre-payment. Payment must be made before records will be released to a third party
MAIL	• Records mailed through US Mail may take up to 15 business days to receive • Records mailed to a third party receive an invoice for pre-payment. Payment must be made before records will be released to a third party

Your request may be delayed if RRS Medical cannot determine the following information:

- Who you are – Your name, date of birth, and correct home address
- What records need to be sent – Specific dates of care/service or body parts examined
- Where you would like the records sent – Complete address of where the records are to be delivered
- How you would like the records sent – Identify if records should be sent through portal, fax, or US mail
- Your signature and authorization date – **You must sign and date the form for it to be valid**

If you have any questions or need assistance, contact RRS Medical at (484) 468 – 1299