INSTRUCTIONS FOR REQUESTING MEDICAL RECORDS

Upper Bucks Orthopaedic Associates 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: (484)468-1299 Fax: 484-468-1247
UBO@rrsnet.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 "Authorization for Disclosure" provided to you. Please **include your phone number and complete address** on your request in the event there are any issues regarding the release of your records.

2. Submit your signed and COMPLETED authorization to the above address, email it to ubo@rrsnet.com , or fax it to 484-468-1247

3. If you are asking for records to be delivered directly to you there is a $20 charge for reproduction and delivery. If you choose to have them delivered directly to another provider there will be **NO CHARGE.**

In order for your request to be processed please be sure to fill out all fields on the medical records release form. If RRS cannot determine;

- **Who you are – Your name DOB and Address**
- **What you need sent – What records, specifically the Dates of Service or body parts examined**
- **Where you would like the records sent – Complete address of where you need records delivered too in addition to a Fax number if you would like them faxed**
- **Your signature and when you signed the Authorization – You must sign and Date the form to be valid**

If you have questions on how to complete the form please contact RRS

Your records will be released within 48 hours of receipt of the request

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

CREDIT CARD INFORMATION			
Customer Name:			
Credit Card Type: ☐ Visa ☐ Master Card ☐ American Express ☐ Discover			
Credit Card Number:			Expiration Date:
Name as it appears on Credit Card:			CVC2 Code:
Payment Amount (US Dollars):			
Signature:			Date:
CREDIT CARD BILLING ADDRESS			
Street Address:			
City:			
State:	Zip/Postal Code:		Country:
Phone Number:		Fax Number:	

Upper Bucks ORTHOPAEDICS

711 Lawn Avenue Sellersville PA 18960

Authorization to Use or Disclose Protected Health Information (PHI)

All sections must be completed

I hereby authorize [Name of Facility] _____ [Full Address of Facility] _____ to release information from the record of:

_____: _____: _____: _____

[Patient Name] [Birth Date] [SSN] [Alias/Married, Maiden Name]

Requesting Party	Receiving Party [If different from Requesting Party]
Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Phone #:	Phone #:

Records are requested for the purpose of: [Provide a detailed description] _____

Would you like to receive your records electronically?

Yes ☐ No ☐ Email Address: (required if electronic delivery is desired) _____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Types of records to be released and approximate date(s) of service (check all that apply):

☐ Inpatient; Dates: _____ ☐ Emergency Dept; Dates: _____

☐ Outpatient; Dates: _____ ☐ Physician Office/Clinic; Dates: _____

2. Specific information to be released (check all that apply):

☐ Consultation Reports	☐ Medical History & Physical	☐ Physician Orders
☐ Discharge Summary	☐ Medication Records	☐ Progress Notes
☐ Laboratory Reports/Tests	☐ Operative Reports	☐ Psychiatric/Psychological Eval
☐ Mammography Report	☐ Pathology Report	☐ Radiology Report
☐ Emergency Dept Records	☐ EKG Results	☐ Discharge Instructions

☐ Other; specify: _____

HIV, Mental Health and Drug & Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated by initialing below: ____ HIV ____ Mental Health (Psychiatric) ____ Drug & Alcohol

I understand that this authorization is effective for a period of 12 months from the date of signature unless otherwise specified below. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here: _____

_____ _____ **or** _____ _____

Signature of patient **Date** **Signature of Parent, Legal Guardian or Authorized Representative *** **Date**

***Relationship to Patient** _____

- Important: Your healthcare provider has selected Record Reproduction Services (RRS) to process and fulfill medical record requests on their behalf. Most requests are completed within 7-10 business days. Questions about your request should be directed to RRS at 484-468-1299.opt.1.
- In most cases, there is no charge to send records directly to a physician. If I request my records to be sent to any entity other than a physician, including for my personal use, I understand that there may be a charge for this service. I agree to pay these charges.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) RRS and its staff/employees have no responsibility or liability as a result of any re-disclosure and (2) such information would no longer be protected by the Privacy Rule (HIPAA), however, such information is always protected by the drug and alcohol regulations.
- My decision to revoke the authorization must be made in writing to the aforementioned facility or RRS. My decision to revoke the authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the authorization. My decision to revoke the authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- Neither the aforementioned facility nor RRS can require me to sign the authorization in order to receive treatment.