

**INSTRUCTIONS FOR REQUESTING MEDICAL RECORDS**

**East Valley Family Physicians 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 [mrr@rrsnet.com](mailto:mrr@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 **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@rrsnet.com](mailto:mrr@rrsnet.com) , or fax it to 484-468-1247
3. There may be a fee for the transfer of your information. Please use the grid below to determine the correct amount:

| <u>Please check one</u>  | <u>Transfer to Whom?</u> | <u>Record Type</u>  | <u>Charge</u> |
|--------------------------|--------------------------|---------------------|---------------|
| <input type="checkbox"/> | Physician                | Chart               | No Charge     |
| <input type="checkbox"/> | 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 @ 484-468-1299**

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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**

## Medical Record Release of Information Authorization

|   |  |  |   |                                    |   |  |  |                                   |   |  |                                       |
|---|--|--|---|------------------------------------|---|--|--|-----------------------------------|---|--|---------------------------------------|
| <b>WHO</b>                                      | <p style="text-align: center; color: red;"><b>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.</b></p> <p>Patient Name: _____ Date of Birth: ____ / ____ / _____ SSN #: (last 4)- _____</p> <p>AKA or Maiden Names: _____</p> <p>Patient Address: _____</p> <p>City: _____ State: ____ Zip Code: _____ Phone: ( ) ____ - _____</p> <p>Email: _____ @ _____ . _____ Fax: ( ) ____ - _____</p>   |  |   |                                    |   |  |  |                                   |   |  |                                       |
| <b>WHERE</b>                                    | <p style="text-align: center;"><b>Doctor you would like information from</b></p> <p>Doctor Or Facility Name: <u>East Valley Family Physicians</u></p> <p>Address: <u>1455 W. Chandler Blvd., Bldg. A, Suite 4</u></p> <p>City: <u>Chandler</u></p> <p>State: <u>AZ</u> Zip Code: <u>85224</u> Fax: <u>(480) 899 – 0681</u></p>   | <p style="text-align: center;"><b>Where you would like info sent to</b></p> <p style="text-align: center; color: red; font-size: small;">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</p> <p style="text-align: center;"><input type="checkbox"/> <b>Self</b></p> <p>Doctor Or Facility Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____ Zip Code: _____ Fax: ( ) ____ - _____</p> |   |                                    |   |  |  |                                   |   |  |                                       |
| <b>WHAT</b>                                     | <p style="text-align: center; color: red;"><b>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.</b></p> <p style="text-align: center;">Dates of Service: - From: ____ \ ____ \ _____ - To: ____ \ ____ \ _____</p> <p style="text-align: center;">Specific Information: _____</p> <p style="text-align: center; background-color: #000080; color: white; padding: 5px;"><b>Records will be delivered BY ELECTRONIC DELIVERY unless otherwise indicated. Deliver on Paper: _____ Yes</b></p> |  |   |                                    |   |  |  |                                   |   |  |                                       |
| <b>WHY</b>                                      | <p><b>Purpose of Disclosure - Please select one:</b></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Referral to Specialist</td> <td><input type="checkbox"/> Insurance</td> <td><input type="checkbox"/> Workman's Comp</td> </tr> <tr> <td><input type="checkbox"/> Legal Investigation</td> <td><input type="checkbox"/> Disability Determination/ Claim</td> <td><input type="checkbox"/> Personal</td> </tr> <tr> <td><input type="checkbox"/> Transfer of Care</td> <td><input type="checkbox"/> 2<sup>nd</sup> Opinion</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>  |  | <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance | <input type="checkbox"/> Workman's Comp | <input type="checkbox"/> Legal Investigation | <input type="checkbox"/> Disability Determination/ Claim | <input type="checkbox"/> Personal | <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> 2 <sup>nd</sup> Opinion | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance   | <input type="checkbox"/> Workman's Comp  |   |                                    |   |  |  |                                   |   |  |                                       |
| <input type="checkbox"/> Legal Investigation    | <input type="checkbox"/> Disability Determination/ Claim   | <input type="checkbox"/> Personal  |   |                                    |   |  |  |                                   |   |  |                                       |
| <input type="checkbox"/> Transfer of Care       | <input type="checkbox"/> 2 <sup>nd</sup> Opinion   | <input type="checkbox"/> 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.**

\_\_\_\_\_  
Signature of Patient or Authorized Representative

Date: \_\_\_\_\_