

**INSTRUCTIONS FOR REQUESTING MEDICAL RECORDS**

Tidewater Physicians Multispecialty Group 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: (757) 866-4005 Fax: (757) 210-3805  
[tpmg@rrsmedical.com](mailto:tpmg@rrsmedical.com)

**In order to 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. **Include your phone number and complete address** on your request in the event of 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 [tpmg@rrsmedical.com](mailto:tpmg@rrsmedical.com), or fax it to (757) 210-3805.

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

<b><u>Check one</u></b>	<b><u>Transfer to Whom?</u></b>	<b><u>Record Type</u></b>	<b><u>Charge</u></b>
<input type="checkbox"/>	Physician	Chart	No Charge
<input type="checkbox"/>	Patient	Chart w/Electronic Delivery	\$6.50
<input type="checkbox"/>	Patient	Chart w/Paper Delivery	\$6.50 + shipping
<input type="checkbox"/>	Physician	Films	No Charge
<input type="checkbox"/>	Patient	Films	\$10.00

4. Records will be delivered by electronic delivery unless otherwise indicated on the **Medical Record Release of Information Authorization**. **PAPER COPIES HAVE AN ADDITIONAL FEE FOR DELIVERY AND LONGER TURNAROUND TIME.**

**RECORDS ARE AVAILABLE VIA SECURE EMAIL**  
Please clearly indicate your email below. If you have any questions, contact RRS @ (757) 866-4005

\_\_\_\_\_ @ \_\_\_\_\_

For your request to be processed, fill out all fields on the release form. Your request may be delayed if RRS cannot determine:

- **Who you are – Your name, date of birth, and address**
- **What records need to be sent – Specific 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 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

Your credit card can be billed directly to avoid any bills being sent to you. Providing a payment upfront may significantly reduce turnaround.

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

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# Medical Record Release of Information Authorization

**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 service, please specify the information 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:

- |   |  |   |
|---|--|---|
| <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:         |

**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**

**Legal Requirements**

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/guardian 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 \_\_\_\_\_