# Instructions for Completing the Medical Records Request Form

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

1) Sign, date, and completely fill out the Medical Records Request provided to you. Include your phone number and complete address on your request in the event there are any questions about your authorization.
2) Submit your signed and COMPLETED Medical Records Request to:

Piedmont Orthopaedic Complex
4660 Riverside Park Blvd
Macon, GA 31210
Fax: (478) 474-8001
Phone: (478) 474-2114

3) There may be a fee associated with the transfer of your information. Please use the grid below to estimate the cost of this transfer.

| **Transfer to Whom?** | **Charge** |
|---|---|
| Physician | No Charge |
| Patient | $6.50 + postage (if applicable) |
| Insurance, Attorney, Other Requesters | $25.88 Processing Fee<br>$0.97 per page (1-20)<br>$0.83 per page (21-100)<br>$0.66 per page (101+)<br>Postage (if applicable)<br>$9.70 Notary Fee (if applicable) |

4) Records will be delivered in an electronic format unless otherwise indicated on the Medical Records Request.
   - If delivered in an electronic format, you will receive a payment notification email. **Please be sure to check your inbox/junk/spam folders.**
   - You have the option of paying online or sending in check.
   - Once paid, you will receive a second email with login credentials to the portal where you can download the records.

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 want records sent – Complete address, fax, or email of where you want records to be delivered
- Your signature and the date you signed the form

Piedmont Orthopaedic Complex has retained a professional service to handle the duplication and transfer of medical records. Your request will be completed within 10 days of the receipt of the request. If you have any questions regarding the process or how to complete the form, please contact:

RRS Medical
600 North Jackson Street, Suite 104
Media, PA 19063
Phone: (484) 468-1299
Fax: (484) 468-1281
Email: mrr@rrsmedical.com

# Medical Records Request

Piedmont Orthopaedic Complex
4660 Riverside Park Blvd
Macon, GA 31210
Telephone: 478.474.2114 Fax: 478.474.8001

| Patient Information | | | |
|---|---|---|---|
| Patient Full Name: | | | Account #: |
| Address: | | | Date of Birth: |
| City: | State: | Zip: | Email Address: |

| Release Information To | | | |
|---|---|---|---|
| *This box must be complete in order for request to be processed* | | | |
| Name/Facility: | | | Email Address: |
| Address: | | | Phone: |
| City: | State: | Zip: | Fax: |
| Purpose of Request<br>☐Personal ☐Treatment ☐ Legal ☐Insurance ☐Disability<br>☐Transfer/Reason:_____ ☐Other:_____ | | | |
| Delivery Method<br>☐ Electronic Portal Access(specify email above) ☐ Fax ☐ Mail - Paper copies ☐Mail - CD | | | |

| Information to Be Released |
|---|
| Dates of Service: From: _____ To: _____<br>☐Abstract/Pertinent Info ☐Operative Report ☐ Office Notes ☐Imaging/Lab/Pathology Reports<br>☐Complete Chart ☐Itemized Billing Statement ☐Other:_____ |

| Authorization to Release Protected |
|---|
| If applicable, I also give permission for the following to be disclosed:<br>- Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)<br>- Behavioral Health Services/Psychiatric Care<br>- Treatment for Alcohol and/or Drug Abuse |

Patient's Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

*(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)*

- This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the clinic took before it received the revocation.
- I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by Piedmont Orthopaedic Complex and its affiliates in no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.
- I understand that I may inspect or copy the information that is used or disclosed.