INSTRUCTIONS FOR REQUESTING MEDICAL RECORDS

Orthopedic Specialists of Seattle **has retained a professional service to handle the duplication and transfer of medical records. The company performing these services is:**

Record Reproduction Services (RRS)
5350 Tallman Ave NW
Suite 500
Seattle , Wa 98107
Phone: (206) 829-5275 - TBD Fax: (206) 212- 9083
OSS@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 issues 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 oss@rrsnet.com , or fax it to **(206) 212- 9083**
3. Records will be delivered on CD-Rom unless otherwise indicated on the **Medical Record Release of Information Authorization**
4. Xray films can be obtained on CD-Rom for a $15 fee

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 Medical Record Release of Information Authorization – You must sign and Date the form to be valid**

Your records will be released within 10 days of receipt of the request.

Requesting records prior to April 2010 may delay responses

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.

If you have any questions on the process or how to complete the form please contact RRS - Addition 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	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
Orthopedic Specialists of Seattle **5350 Tallman Ave NW** **Suite 500** **Seattle , Wa 98107**	☐ Self **Doctor Or Facility Name:**_____ **Address:** _____ **City:** _____ **State:** _____ **Zip Code:** _____ **Fax:** ( ) _____ - _____

WHAT

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.

Please note that processing times for records April 2010 to the present are significantly less than requesting your whole chart. Whole charts can take up to two weeks from the time of receipt

Dates of Service: - From: __________ \ _____ **- To:** __________ \ _____

Specific Information: _____ **Deliver on Paper:** _____ **Yes**

WHY

Purpose of Disclosure - Please select one:

☐ Referral to Specialist	☐ Insurance	☐ Workman's Comp
☐ Legal Investigation	☐ Disability Determination/ Claim	☐ Personal
☐ Transfer of Care	☐ 2nd Opinion	☐ 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 ____/_____/_____

y 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 herwise indicated.

Agree _____ Disagree _____ - AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
Agree _____ Disagree _____ - Psychiatric care and/or psychological assessment
Agree _____ Disagree _____ - Treatment for alcohol and/or drug abuse.
Agree _____ Disagree _____ - 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.

_____ Date: _____

Signature of Patient or Authorized Representative