RSRS Authorization to Release Medical Records from the Practice of Dr. Mark Sager

Only one form is needed for your family. This form allows you to release a copy(ies) of your medical record. Your medical record is critical for continuity of care and tracks history including: medications, vaccinations, surgeries, bloodwork, ECGs and various treatments. Please fill in the name of each family member whose record was with Dr. Mark Sager and carefully follow the instructions for each section. Start by completing sections A through C below and then turn to page 2 and complete sections D through H. ***If you prefer to complete our online form instead, visit www.recordsolutions.ca/DrSager***

By signing this form each patient / authorized representative, confirms his/her right and authority to receive the information requested. I confirm that RSRS, in releasing this information, is exercising good faith and reasonable action, given its powers and duties in accordance with the Personal Health Information Protection Act (PHIPA 2004, c.3, Sched. A, s. 71 (1)).

Please return completed form using any method below.

Email: medicalrecords@rsrs.com **Fax:** 1 (877) 398-5932 **Mail:** Dr. Mark Sager c/o RSRS 111 St. Regis Cres. S., Toronto, ON M3J 1Y6

Section A – I want to order my own medical record

First Name:_____ **Last Name:**_____ **Sex:** ☐ Male Female

Maiden/Other Name(s):_____ **Health Number:**_____

Email:_____

Date of Birth (MM/DD/YYYY):_____ **Signature:** _____

Section B – I want to order medical record(s) of other family members *(Copy this page if there are more than 5 family members.)*

Record #2 (Patient signature required for ages 16 and over)

First Name:_____ **Last Name:**_____ **Sex:** ☐ Male ¨ Female

Maiden/Other Name(s):_____ **Health Number:**_____

Email:_____

Date of Birth (MM/DD/YYYY):_____ **Signature:** _____

Record #3

First Name:_____ **Last Name:**_____ **Sex:** ☐ Male Female

Maiden/Other Name(s):_____ **Health Number:** _____

Email:_____

Date of Birth (MM/DD/YYYY):_____ **Signature:** _____

Record #4

First Name:_____ **Last Name:**_____ **Sex:** ☐ Male ¨ Female

Maiden/Other Name(s):_____ **Health Number:** _____

Email:_____

Date of Birth (MM/DD/YYYY):_____ **Signature:** _____

Record #5

First Name:_____ **Last Name:**_____ **Sex:** ☐ Male ¨ Female

Maiden/Other Name(s):_____ **Health Number:** _____

Email:_____

Date of Birth (MM/DD/YYYY):_____ **Signature:** _____

Section C – Who would you like us to send certified copies of your family's medical records to?

☐ **Drs. Krantz / Ostro** (use Download Delivery pricing in Section F) ☐ **You and Drs. Krantz / Ostro** ☐ **You only** ☐ **Another physician** (indicate address in Section E)

Section D – How would you like to receive certified copies of your family's medical records?

¨ **Option 1 - Secure download to my computer *No Shipping Charge**

Email Address: _____ (Provide one email address to send download instructions.)

¨ **Option 2 - Mail USB drive to me *Add $20 for shipping and administration for each USB ordered**

¨ **Option 3 - Mail paper to me *Add $30 for shipping and administrative fees for each record**

[All shipping and administration fees are included in the Fee Calculation Chart below.]

Section E– Where would you like us to send certified copies of your family's medical records?

(Complete if you chose Option 2 or 3 in Section D)

Mr. / Mrs. / Ms. / Dr.

First Name:_____ **Last Name:**_____

Street Address:_____ **Apt #:**_____

City/Town.:_____ **Prov.:**_____ **Postal Code:**_____

Section F – Please use the Fee Schedule below to determine the total fee(s) for the administration and shipping of your medical record(s). HST is also included.

Fee Schedule

Number of Records	Download Delivery	USB Delivery	Paper Delivery
1	$106.79	$129.39	$140.69
2	$213.57	$236.17	$281.37
3	$286.46	$309.06	$388.16
4	$381.94	$404.54	$517.54
5	$477.43	$500.03	$646.93

This fee will cover the cost of production of your most current volume. In the case of a very large record, an RSRS representative will contact you as this may require an administrative surcharge. **A $10/patient discount is applied if you are ordering records for 3 or more patients.**

Please contact RSRS at 1-888-563-3732:

- If you are ordering records for more than 5 family members.
- If you would like to order multiple copies of a record.
- If you would like to order records with more than one USB

If your preference is not covered by this form.

Payment Amount: $_____

Section G – Payment Information

To Pay by Cheque or Money Order: Make cheque payable to: RSRS, Inc. and mail cheque with this form in the enclosed envelope, addressed to: RSRS, 111 St. Regis Cres. S., Toronto, ON M3J 1Y6 (There is a $25 charge for returned cheques)

¨ Visa ¨ MasterCard ¨ Amex ¨ Visa Debit **Credit Card Number:**_____

Name on Card:_____ **Expiry Date:**_____ ¨ Billing Address is the same as Section E

Cardholder's Signature: _____

Billing Street Address:_____ **Apt #:**_____

(Please complete only if billing address is different than in Section E)

City/Town.:_____ **Prov.:**_____ **Postal Code:**_____

Section H - Main Contact Information

I am signing on behalf of (check all that apply) ¨ **Myself** ¨ **Child(ren)** **Dependent Adult(s)**

First Name:_____ **Last Name:**_____

Address):_____ **Apt #:**_____

City/Town.:_____ **Prov.:**_____ **Postal Code:**_____

Email Address:_____ **Date (MM/DD/YYYY):**_____

Preferred Phone Number:_____ **Signature:** _____

RSRS - Record Storage & Retrieval Services, Inc. is a fully compliant, physician-managed medical records facility. RSRS provides secure, confidential medical record storage & retrieval services to Canadian physicians and certified record copies to their patients. RSRS adheres to strict privacy guidelines and always protects your information. Please allow 4-6 weeks for delivery once authorization and payment are processed. RSRS may contact you if your medical record is oversized. Personal Information: The patient consents to RSRS's collection, use and disclosure of all personal information disclosed to RSRS in this form, in the application process or in the ongoing administration of this agreement. More specifically, RSRS will collect and use the patient's personal identifying information to properly identify and contact the patient or to perform any other necessary functions relating to the administration of this agreement or otherwise as required by law. While we will never disclose personal identifying information to a third-party company, you are agreeing to receive health communications from us (including any of our affiliated brands, divisions or affiliated companies) at the time you provide your email address to us (Opt-In). If you provide your email address through a channel that does not have a way for you to affirmatively Opt-In, you agree that by providing your email address you are opting-in. You will be responsible for opting-out of receiving future communications by clicking on the link provided at the bottom of our email communications or by contacting us (each an Opt-Out). The agreement shall be construed according to the laws of the province of Ontario, Canada.