# Authorization to Release Medical Records from the Practice of Dr. Kate Elizabeth (Beth) Jolley

Only one form is needed for your family. This form authorizes RSRS to release a copy of your digitized medical record(s) to yourself, to **Dr. Adewole Shamsideen Abiola** or to another doctor of your choosing. 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 information below for each family member whose record was with **Dr. Kate Jolley** 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/DrKJolley***

By completing and signing this form, each patient/authorized representative, confirms his/her right to authorize the release of the medical record as instructed. I/We 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 both sides of this completed form using any method below.**

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

## Section A - I want to order my own medical record (Please print except for Signature)

**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?

☐ **Dr. Abiola only**
Record will be sent directly to Dr. Abiola. Download fee applies. Proceed to Section F

☐ **Dr. Abiola & You**
If you are getting a copy for yourself, we can send a digital copy to Dr. Abiola at no extra cost. Proceed to Section D.

☐ **You Only**
Record will be sent directly to you. We strongly recommend this option if you wish to take your record to another doctor. Proceed to Section D

☐ **Another Doctor**
If you want a USB or Paper Copy sent directly to another doctor. Proceed to section D.

## Section D – If you are receiving a copy for yourself and/or family members, how would you like to receive it?

**Option 1 - Secure download of PDF format digital copy** (Note: add email addresses for each patient in Section B)

**Option 2 - Mail USB drive to me *$20+HST for the 1st & $10+HST per additional patient, has been pre-applied to the pricing in Section F**

**Option 3 - Mail paper to me *$30+HST per patient has been pre-applied to the pricing in Section F**

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

## Section E– If you chose to receive a USB or Paper copy, please provide the mailing address. Please attach another page if shipping information for other family members is different.

Mr. / Mrs. / Ms. / Dr.

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

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

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

## Section F - Please refer to the Fee Chart below for the total amount payable for the preparation and delivery of your medical record(s). The fee per record is $98.50 + 13% HST. The chart shows the final fees payable including HST and discounts.

**Fee Schedule (HST is included in each case. Delivery to Dr. Abiola is included with USB and Paper fees, if that scenario applies to you)**

| Number of Records | Direct Download to Dr. Abiola and/or self. | USB Delivery | Paper Delivery |
|---|---|---|---|
| 1 | $111.31 | $133.91 | $145.21 |
| 2 | $222.61 | $256.51 | $290.41 |
| 3 | $333.92 | $379.12 | $435.62 |
| 4 | $400.02 | $456.52 | $535.62 |
| 5 | $500.03 | $567.83 | $669.53 |

This fee will cover the cost of production of your most current volume. If you require your full medical record from Dr. Jolley beyond that, please contact RSRS as additional fees may apply.

**A $10/patient discount has been pre-applied if you are ordering records for 4 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 USB or Paper record.
- If you would like to order records with multiple formats
- 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** 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 physician-managed medical records facility. RSRS provides secure patient record retention services to Canadian physicians and also assists patients and authorized requesters in obtaining certified record transfers and copies. For record copy requests, please be patient as the fulfillment of record copies is dependent on date of practice closure, delivery of records to RSRS, processing of record copies or scans and then delivery to the requester. The timing can greatly vary from a few weeks to a few months.

Personal Information usage: By signing this agreement, the requester consents to RSRS's collection and use of personal information for purposes of confirming the identity of the requester, fulfillment of the record request and ongoing administration where necessary. RSRS will not ever disclose any patient information to a third party, unless specifically first disclosed to and agreed to by the patient or unless under court order to do so.

By signing this agreement and providing your email address above, you are also agreeing to receive The Health Insider – a bi-weekly email containing health resources and news items of interest to Canadian patients in the management of their health care. There is no additional cost to you for this service and you may unsubscribe to this at any time. This agreement shall be construed according to the laws of the province of Ontario Canada.