RSRS Authorization to Release Medical Records from the Practice of Dr. Matthew Johnson

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. M. Johnson**, 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 name of each family member whose record was with Dr. Matthew Johnson 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/Dr**MatthewJohnson*

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 completed form using any method below.

Email: medicalrecords@rsrs.com **Fax** 1 (877) 398-5932 **Mail:** Dr. Johnson 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. Johnson only**
Record will be sent directly to Dr. Johnson
Download fee applies. Proceed to Section F

☐ **Dr. Johnson & You**
No additional charge for your copy if "download" option is selected.
Proceed to next section.

☐ **You Only**
Record will be sent directly to you.
Download fee applies. Proceed to Section D

☐ **Another Doctor**
We recommend that you take the record for yourself and deliver it personally.

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. Johnson is included with USB and Paper fees, if that scenario applies to you)

Number of Records	Direct Download to Dr. Johnson 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. 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 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 Inc**. and mail cheque with this form in the enclosed envelope, addressed to: RSRS Inc, 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.