The Medical Practice of
Dr. A.P. Eng 黃奕平家庭醫師

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please review this form from RSRS. I strongly recommend that you obtain a certified copy of your medical record so that the information is always available to you and/or your new doctor.

Dr. A. P. Eng

Instructions

Option A: Complete and return this paper form to RSRS via email, fax or mail.

Scan & email to: (掃描及電子郵件)
medicalrecords@rsrs.com

or

Fax to: (傳真)
1.877.398.5932

or

Mail to: (郵寄)
RSRS Inc.
111 St. Regis Cres. S.,
Toronto, ON M3J 1Y6

Option B: If you prefer, you can request your record(s) online at **www.DrEng.ca** (You'll need your PHN to complete the online form.)

Option C: Contact an RSRS patient services representative at **1 (888) 563-3732, Ext. 1**

病歷申請之途徑

如果黃奕平(Dr.Eng)醫師是您的家庭醫師, 請用此表格填寫病歷申請。申請方法有三種:

A方案 敬請用英文填寫此表格, 然后用傳真, 電子郵件或者郵局寄出。

B方案 敬請用網上申請。網址為: www.DrEng.ca(如果使用此方法, 您將需要提供健康卡之卡號。)

C方案 敬請致電RSRS patient service (RSRS 客服專線) 1-888-563-3732 轉1線。

1 Tell us whose medical record(s) you are requesting

Please include all family members who were patients of Dr. Eng and whose records you are requesting. Use an additional sheet of paper if necessary.

Main contact information (您的個人資料)

First name _____ Last name _____

Phone number _____ Email address _____

Signature _____ Date _____

☐ **I am requesting my own medical record**
*(Please add your **Personal health number** and **Date of birth** below)*

Personal health number (PHN) _____ Date of birth _____

Other family members (patients of Dr. Eng only) (如果您的家人是黃奕平醫師之患者)

First name	Last name	Personal health number (PHN)	Date of birth	Patient signature or parent/guardian (age 16 or older)

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 Information Protection Act (PIPA). Signatures on this form are valid for 6 months.

(請翻至下一頁) **Continued ➡**

AUTHORIZATION TO RELEASE MEDICAL RECORDS (Continued)

2 Tell us how you'd like to receive your medical record(s)

Please note: Shipping and Handling charges apply to CD and Paper only.

Choose only one:

- ❑ **Secure download** (安全下載) ***FREE SHIPPING!*** (Go to Section 4)
  Email Address: (required) _____
- ❑ **CD** (光碟) **Add $12** shipping and handling. (1 CD per household)
- ❑ **Paper** (紙) **Add $20** shipping and handling for each record

Complete Section 3

3 Tell us your mailing address. (郵寄地址)

Please complete this section *ONLY* if you chose **CD** or **Paper**. Otherwise, leave empty.

One destination per order form: all medical records will be sent to only one address or email.

Name _____

Address _____ Apt. # _____

City _____ Prov. _____ Postal code _____

(It is recommended that you obtain your record for yourself now. You can make copies for your new doctor, as required.)

4 Calculate the fee for your medical record(s)

The fee for each patient record is $94.50 including sales tax. (稅後費用)

To determine the total fee, fill in the blanks.

RSRS is committed to reconnecting patients with their medical records. Should you have a requirement that is not addressed by this form, (e.g., if you want **more than one copy** of the same patient record), contact an RSRS patient services representative at 1.888.563.3732, Ext. 1, or email medicalrecords@rsrs.com.

Tell us how many patients are requesting medical record(s): (申請病歷之數量)

I am ordering _____ (Number of Patients) medical record(s) × $94.50 = _____

Tell us if you are entitled to a family discount

❑ I am ordering for **3 or more** patients, so please deduct 20% = -_____
(如果您一次性申請三位以上患者之病歷, 即可獲得20%之優惠)

Subtotal (小記) = _____ (Subtotal)

Shipping & Handling (from Section 2) (運費) _____ (S&H charge, if any)

Total Payable (總計) = _____ (Total)

5 Tell us how you'd like to pay for your medical record(s).

❑ **Credit card** (信用卡)

❑ **Visa** ❑ **MasterCard** ❑ **Amex** ❑ **Visa Debit**

Credit Card Number _____

Name on card _____ Expiry date (mm/yyyy) _____ Cardholder's Signature _____

❑ **Cheque or Money Order** (支票/匯票)
Make cheque payable to: RSRS, Inc.
Mail cheque with this form to: RSRS Inc.
111 St. Regis Cres. S, Toronto, ON M3J 1Y6
(There is a $25 charge for returned cheques)

This package has been sent to you by RSRS – Record Storage & Retrieval Services, Inc. on behalf of Dr. Eng. RSRS is a fully compliant, physician-managed medical records facility. RSRS provides secure, confidential medical record storage & retrieval services to Canadian doctors and their patients. RSRS adheres to strict privacy guidelines and always protects your information.

Note: Medical records sent to patients consist of the most recent file for each patient as maintained by the doctor. Please allow 4-6 weeks for delivery once authorization and payment are received.
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. RSRS will only collect, use or disclose the patient's personal information to 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. The agreement shall be constructed according to the laws relating to Ontario. CRA #885167544.

Once you've completed this form, scan & email, fax or mail both pages to RSRS. See top of page 1 for complete instructions.