RSRS

Authorization to Release a Certified Copy of Medical Records from the Practice of Dr. Geoff Davis

Email to:
medicalrecords@rsrs.com

Fax to:
(877) 398-5932

Mail to:
Dr. Geoff Davis
c/o RSRS
111 St. Regis Cres. S.,
Toronto, ON M3J 1Y6

One form per family. This form is used to obtain a certified copy of your medical record. This is important in every scenario, including should you be transferred to another doctor within the HarbourView system. Your medical record is critical for continuity of care, patient involvement, a new doctor, and many other details you need to track, such as: medication history, vaccinations, surgeries, bloodwork history, ECGs and all other courses of treatment – both historical and current. Please fill in the name of each member of your family whose record was with Dr. Geoff Davis. Follow the instructions on the form and then complete payment information on the back. T*o use online form instead, visit www.recordsolutions.ca/DrDavis*

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)). Signatures on this form are valid for 6 months.

Section A – I want to order my own medical record

Last Name | First Name | Second Name

☐ 16 years of age or older ▼ | Health Number | Version Code | Date of Birth *(yyyy/mm/dd)* | Sex ☐ M ☐ F

Signature
X

Note: Each patient aged 16-years of age or older must sign where indicated.

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

1
Last Name | First Name | Second Name
Health Number | Version Code | Date of Birth *(yyyy/mm/dd)* | Sex ☐ Male ☐ Female
☐ 16 years of age or older ▶ | Signature X | Email

2
Last Name | First Name | Second Name
Health Number | Version Code | Date of Birth *(yyyy/mm/dd)* | Sex ☐ Male ☐ Female
☐ 16 years of age or older ▶ | Signature X | Email

3
Last Name | First Name | Second Name
Health Number | Version Code | Date of Birth *(yyyy/mm/dd)* | Sex ☐ Male ☐ Female
☐ 16 years of age or older ▶ | Signature X | Email

4
Last Name | First Name | Second Name
Health Number | Version Code | Date of Birth *(yyyy/mm/dd)* | Sex ☐ Male ☐ Female
☐ 16 years of age or older ▶ | Signature X | Email

Section C – I want my medical records delivered by the following method *(choose only one)*

To ensure that you receive proper continuity of care and that medical tests and reports are available to you or your new doctor, you must order a certified copy of your current medical record(s).

☐ **Secure download** to my computer
(No shipping charge)
Email Address: _____
Provide one email address where download instructions should be sent. (One download per household)
▼ Section E

☐ Mail **CD** to me
(Complete Section D)
Add $12 shipping and handling.
(1 CD per household)
▼ Section D

☐ Mail **Paper** to me
(Complete Section D)
Add $20 shipping and handling
for each record
▼ Section D

Continued ➡

Payment for Copy and Release of Medical Records

Section D – I want my/our medical records mailed to the following address *(complete only if you chose the CD or Paper options above)*

Complete mailing address in this section *only* if you chose **CD** or **Paper** in **Section C**.

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

Mailing Address ▶

or

☐ same as Section G

Last Name | First Name

Apt. # | Street

City/Town | Prov. | Postal Code

Section E – Calculate the fee for copying your medical records. *(Not covered by OHIP)*

Complete this section to calculate the fee to retrieve, assemble, copy and transfer the medical record(s) you've requested on the other side of this form.

Fee for copying medical records
Print total from calculation on right.

$ _____ (Copying cost) = _____ Quantity of medical record(s) × $94.50

☐ **Family discount**
If you are ordering for **3 patients** or **more**, deduct **$20**/record

_____ (Family discount)

If you would like more than one copy of the same patient file, contact an RSRS patient services representative at 1.888.563.3732, Ext. 1 or email medicalrecords@rsrs.com.

*For special circumstances (e.g., urgent requests and financial considerations) contact **patient services** at (416) 398-0638, Ext.1*

Comments

_____

_____

_____

Subtotal
(After deduction, if any)

_____ Subtotal

Shipping & handling *Select One (See Section C)*
☐ Download = $0
☐ CD = $12/household
☐ Paper = $20/patient

_____ (S&H charge, if any)

Total
(Subtotal + S&H)

_____ Total

HST
(Total x 0.13)

_____ Sales Tax (13%)

Grand Total
(Total + HST) =

_____ Grand Total

Section F – Payment method

☐ Credit Card

☐ Visa ☐ MasterCard ☐ Amex ☐ Visa Debit

_____
Credit Card Number

_____ _____
Name on card | Expiry date (mm/yyyy)

_____
Cardholder's Signature

☐ Cheque or Money Order
Make cheque payable to: **RSRS, Inc.**

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)

Billing Address ▶

or ☐ same as Section G

Apt. # | Street

City/Town | Prov. | Postal Code

Section G – Main contact information and signature

Last Name | First Name | Second Name

I am signing on behalf of *(check all that apply)*
☐ myself ☐ child(ren) ☐ dependent adult(s)

Apt. # | Street

Email | Date *(yyyy/mm/dd)*

City/Town | Prov. | Postal Code

Home Telephone No. ( ) | Work Telephone No. ( ) | Signature X

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 doctors. RSRS adheres to strict privacy guidelines and always protects your information. Please allow 4-6 weeks for delivery once authorization and payment are received. 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. 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.