MEDICAL RECORD ORDER FORM

Princeton Orthopedic Associates has contracted with Record Reproduction Service (RRS) to handle the duplication and transfer of medical records :

Record Reproduction Services
600 North Jackson Street
Suite 104
Media, PA 19063
Phone: 484-468-1299
Fax: 484-468-1281
rrsmedia@rrsnet.com

In order to standardize and expedite all requests for patient information we have developed the following policy. –

- Sign, date and completely fill out the Authorization to Release medical Records provided to you.
- Make a check payable to RRS or fill out the credit card form below. We have included a form to help you determine you check amount
- Return payment to the above address OR FAX TO 484-468-1247 with the authorization
- If you are at Princeton Orthopedic Associates office, place the forms in the supplied envelope and place in the lock box.

Your records will then be copied within 48hrs or next scheduled visit. RRS will mail your records within 24hrs of copying them.

You can order records online @
www.rrsmedical.com/poa

Item	Qty	Amount Each	Extension
Records – paper copies		$20	
X-rays – Paper copies*** - free with records		$10	
Records on Cd – CD & Paper copies & includes X-rays		$35	
MRI-s – on CD Only		$10	
Total Fee -			

***- X-rays are provided printed on a 8 ½ x 11 paper.
CHECKS SHOULD BE MADE PAYABLE TO *RECORD REPRODUCTION SERVICES (RRS)* AND MUST ACCOMPANY YOU REQUEST FOR RECORDS. IF THE CREDIT CARD FORM IS NOT COMPLETED BELOW REQUEST WILL BE RETURN TO YOU.

Please include your phone number and complete address on your request in the event that there are any issues regarding the release of your records.

Completion of Transaction will take approximately 2 weeks

Thanks for your cooperation in this matter.

CREDIT CARD INFORMATION			
Customer Name:			
Credit Card Type: ☐ Visa ☐ Master Card ☐ American Express ☐ Discover			
Credit Card Number:			Expiration Date:
Name as it appears on Credit Card:			CVC2 Code:
Payment Amount (US Dollars):			
Signature:		Date:	
CREDIT CARD BILLING ADDRESS			
Street Address:			
City:			
State:	Zip/Postal Code:	Country:	
Phone Number:	Fax Number:		

Authorization to Release Medical Records

I _____authorize Record Reproduction Service contracted by Princeton Orthopaedic Associates to release all of my medical records, including test results, Doctor's notes, clinical and staff notes.

From _____ until the present.

- ☐ Including mental health and HIV information
- ☐ Excluding mental health and HIV information
- ☐ Including all Drug and Alcohol use
- ☐ Include all STD information
- ☐ Include any Psychological Notes

PLEASE complete this form in its entirety and print clearly to ensure records are forwarded properly due to there confidential nature. This will help omit any unnecessary delays.

Records pertaining to:

Name of Patient:_____
Date of Birth: _____
Address :_____
_____
Phone#: _____
Email : _____

Please forward records to:

Name: _____
Address: _____
_____
Phone#: _____
Fax#: _____

Patient Signature:_____ Date:_____

THIS FORM MUST ACCOMPANY YOUR PAYMENT OR YOUR WEB PAYMENT CONFIRMATION. REQUESTS NOT DONE ONLINE NEED TO INCLUDE THE COMPLETED MEDICAL RECORD ORDER FORM. FAILURE TO PROVIDE ALL COMPLETED DOCUMENTS WILL RESULT IN DELAYS IN DELIVERING YOUR RECORDS AND POSSIBLY THE REQUEST BEING RETURNED TO YOU.

Thank you for your cooperation in this matter.