WRITTEN REQUEST FOR MEDICAL RECORDS FROM CENTENNIAL MEDICAL GROUP

Centennial Medical Group has retained a professional service to handle the duplication and transfer of medical records. The company performing these services is:

Record Reproduction Services (RRS)
600 North Jackson Street
Street Suite 104
Media, PA 19063
Phone: 484-468-1299 Fax: 484-468-1249
cmg@rrsmedical.com

In order to standardize and expedite all requests for patient information, please follow the instructions below:

1. Sign, date and completely fill out the **Medical Record Release of Information Authorization** provided to you. Please include your phone number and complete address on your request in the event there are any issues regarding the release of your records.
2. Submit your completed and signed release via mail to the above address, email to cmg@rrsmedical.com, or fax to 484-468-1249.
3. There may be a fee for the transfer of your information.
4. Records will be delivered on CD-Rom unless otherwise indicated on release.

You may also request and/or track your request for medical records at request.rrsmedical.com

In order for your request to be processed, please fill out all fields on the release form. RRS must be able to determine all of the below information:

- Who you are - your name, date of birth, and address
- What you need sent - what records, specifically the dates of service or body parts examined
- Where you would like those records sent - complete address of where you need records mailed or fax number
- Signature - you must sign and date the form for this request to be completed

Your medical records will be sent within 10 days of receipt of request.

MEDICAL RECORD RELEASE OF INFORMATION AUTHORIZATION

Please complete all fields below. Missing information will result in delay of medical record delivery.

PATIENT INFORMATION

Name:_____ Date of Birth:_____

Other/Maiden Names:_____ Last 4 digits of SSN:_____

Address:_____ City: _____ State: _____ Zip: _____

Email:_____Phone: _____ Fax: _____

INFORMATION FROM	INFORMATION TO
Centennial Medical Group - Elkridge 8186 Lark Brown Road Suites 201,202 Elkridge, MD 21075 Phone: 410-730-3399 Fax: 443-478-4729	☐ SELF Doctor/Facility Name:_____ Address:_____ City:_____ State:_____ Zip:_____ Fax:_____

MEDICAL RECORD SPECIFICATIONS

Note: larger files will take longer to process and deliver

Dates of Service: Start Date:_____/_____/_____ End Date: _____/_____/_____

Specific Information:_____

Note: Records will be delivered on CD-Rom unless otherwise indicated. Deliver on Paper ☐

PURPOSE OF DISCLOSURE

_____ Referral to Specialist _____ Insurance _____ Workman's Comp

_____ Legal Investigation _____ Personal _____ Disability Determination/Claim

_____ Transfer of Care _____ Second Opinion _____ Other:_____

LEGAL REQUIREMENTS

You must agree or disagree to each of the following. Disagreeing to any of the following may result in portions of your medical file being withheld from disclosure.

Unless otherwise revoked, this authorization will expire six months from the date which it was originally signed or on the following date:___/___/_____

My evaluation, diagnosis, and/or treatment relating to the conditions listed below may be released to the requestor identified above for the following types of records unless otherwise indicated:

Agree_____ Disagree_____ N/A_____ : AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
Agree_____ Disagree_____ N/A_____ : Psychiatric care and/or psychological assessment
Agree_____ Disagree_____ N/A_____ : Treatment for alcohol and/or drug abuse
Agree_____ Disagree_____ N/A_____ : Mental health treatment

Note: failure to complete this section will automatically imply a declination of the above.

AGREEMENT

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure continued treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that there may be a fee for this service.
Requests cannot be processed without proper authorization. Minors must have a parent signature. Individuals requesting records on deceased or adult patients must provide the required Power of Attorney or other supporting legal documents.

_____ _____

Signature of Patient or Authorized Representative Date