Read all information carefully.

General Information
MetalQuest, Inc. is the Trustee for the electronic portions of Mt. Vernon Hospital Patient Health Records (medical records) and Radiology Records (x-rays and other radiology tests) formerly located in Mt. Vernon, NY.

How to Request Patient Health Records and Radiology Records
If you were a patient at Mt. Vernon Hospital please complete the Release of Information Authorization Form (included in this document) in its entirety. You (the patient) must include a copy of any one of the following: your State Issued ID, State Driver's License, or Birth Certificate. Your notarized signature is acceptable in place of the State ID, Driver's License or Birth Certificate. If you are a Parent (requesting records for a minor child), Legal Guardian or other Patient Representative, please follow the additional instructions located directly on the Release of Information Authorization Form in addition to sending a copy of your State Issued ID or Drivers License. Your notarized signature is acceptable in place of the State ID or Driver's License.

Mail the completed form, copy of identification and any additional documentation (as required) to:

MetalQuest, Inc.
ATTN: SSHS - Release of Information Department
PO Box 46364
Cincinnati, OH 45246-0364

If you have questions about how to complete the form, MetalQuest can be reached at:

Phone: 513-898-1022
Fax: 513-242-5059
Email: Retrieve@MetalQuest.com

Format
Patient Health Records can be sent in the following ways, depending on the nature of the record:

- ☐ Digitally via CD/DVD disk
- ☐ Via encrypted download using an email link.
- ☐ Via Facsimile Transmission (100 Pages or less)

Please check the box next to your preferred method. We will make every effort to comply with your choice if possible. Diagnostic images cannot be sent via fax.

Release Process
Requests for patient records from MetalQuest are processed using the following steps:

1. The request is received via submission of a properly completed MetalQuest Mt. Vernon Hospital - Mt. Vernon Release of Information Authorization form. The form may be obtained at www.metalquest.com/MQInnerTrust.html. The completed form should be delivered to MetalQuest by one of four methods: email, fax, USPS or courier. The original request is imaged and archived and is data-entered in our database using a unique Request ID number. The request is vetted for required documentation; a search is done of indexed records and a determination made as to whether the request can be fulfilled. If yes, a response requiring a $25.00 deposit is sent to the Requestor. If not, a response is sent asking for more information and/or required documentation. These responses occur within 72 hours of receipt of the request. All contact with the requestor is logged, as are all steps of the process.

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2. When the deposit is received, the records that are found to be available for the request are retrieved and queued for burning to CD/DVD. When the records have been retrieved, the request is flagged for final billing and an invoice is mailed to the responsible party. Upon receipt of payment, the records are shipped through a delivery process that requires an adult signature.

3. The request data and logging pertaining to it are archived for the life of the trusteeship.

Please note that MetalQuest will prepare and ship the complete Patient Health Record and/or Radiology Record unless otherwise directed on the Release of Information Authorization Form. If only specific information or portion of the record(s) is requested, special handling charges apply.

Fees

The following fees are charged for processing the Release of Information Authorization.

Description	Fee
Medical Records	$0.75 per page plus postage or courier fee
Radiology Records (x-rays)	$25.00 minimum (includes up to 25 images) plus $1.00 per image over 25 plus postage or courier fee
Special Handling Charges	$250.00 per hour for the first hour; $50.00 per hour for each additional hour plus postage or courier fee. The $0.75 per page fee does not apply.
Records Certification Fee	$50.00 per certification

Upon receipt of invoice, send payment to:

MetalQuest, Inc.
ATTN: SSHS Release of Information Department
PO Box 46364
Cincinnati, OH 45246-0364

Shipping

All records will be shipped. Under no circumstances will MetalQuest accept personal deliveries of Release of Information Authorization Forms, payments or arrangements for pickup at MetalQuest.

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COMPLETE ALL FIELDS - DO NOT SIGN A BLANK FORM - PLEASE PRINT OR TYPE CLEARLY
YOU MUST RETURN ALL PAGES TO METALQUEST

PATIENT INFORMATION:

PATIENT NAME: (Last, First, Middle)	DATE OF BIRTH: (MM/DD/YYYY)
MAIDEN NAME:	MEDICAL RECORD NUMBER(S):
ADDRESS:	SOCIAL SECURITY NUMBER: TELEPHONE NUMBER:
EMAIL: (Do not provide address if you do not wish to be contacted via email)	FAX NUMBER:

I hereby authorize MetalQuest, Inc, Trustee for the former Mt. Vernon Hospital- Mt. Vernon, NY, to release and disclose medical information to the recipient listed below. I have been a patient of Mt. Vernon Hospital or I am the Patients Legally Authorized Representative. I understand that the Trustee has legally protected health information about me or the person I represent.

RECIPIENT INFORMATION: (Information will be sent to the person listed below)

FULL NAME:	
ORGANIZATION NAME:	
ADDRESS:	
TELEHONE NUMBER:	FAX NUMBER:
EMAIL: (Do not provide address if you do not wish to be contacted via email)	

INFORMATION TO BE RELEASED: (Check blocks and fill in fields applicable to this request)

Type of Information to Be Released and Disclosed:

- ☐ Patient Health Record (Medical Records)
- ☐ Radiology Records (X-Rays and other Radiology Tests)
- ☐ Other (Please Specify)____

(**NOTE:** MetalQuest will prepare and ship the complete Patient Health Record and/or Radiology Record unless otherwise directed above. Please see the attached information sheets for fees.)

Reason for Request:

- ☐ Medical Treatment
- ☐ Disability
- ☐ Employer
- ☐ Insurance
- ☐ Legal
- ☐ At the Request of the Individual
- ☐ Other_______________________

Send Release of Information Invoice To:

- ☐ Patient listed above
- ☐ Recipient listed above
- ☐ Other Responsible Party listed below:

Name/Organization_______________________________________

Street Address____

City, State, Zip____

Contact Name______________________Phone________________

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I fully understand that the information to be disclosed includes my identity, diagnosis and treatment history and may include information regarding **ALCOHOL AND/OR DRUG/SUBSTANCE ABUSE, BEHAVIORAL OR MENTAL HEALTH SERVICES, GENETIC TESTING, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED AND INFECTIOUS DISEASES, AND AIDS AND HIV INFORMATION.**

This authorization will automatically expire in 90 days after the date below, or sooner by my choice, in which case this authorization will expire on ____ (date) or _____________________________________ (event). A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken by MetalQuest, Inc. in reliance upon this authorization. If I choose to revoke this authorization, I must do so in writing to MetalQuest, Inc. to the address listed at the end of this document.

I understand that any release and disclosure of my health information carries with it the potential for re-disclosure and the information may not be protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.

MetalQuest, Inc. is not a healthcare facility and as a result does not condition treatment or payment on whether you sign this form. However, MetalQuest is unable to release your records unless this form is signed.

I hereby state that I have read and fully understand the above statements as they apply to me. I consent to the release and disclosure of the records for the purpose(s) stated above.

PATIENT SIGNATURE: (If the patient is a minor, age 13 to 18, and received mental health and/or substance abuse treatment, then he/she must sign this authorization.)	DATE: (MM/DD/YYYY)
Parent or Patient's Legal Representative Signature:	Printed Name, Address and Telephone Number of Parent or Patient's Legal Representative:
Description of Authority to Act on Behalf of Patient:	Reason Patient is Unable to Sign
Attach All Applicable Documents of Authority to support your claim of being the Patients Legal Representative: Guardianship, Executor or Estate, Power of Attorney, Birth Certificate, Certificate of Death	

State of ________________________________

County of________________________________

On this _____ day of ____________, 20____, before me, the undersigned notary public, personally appeared ___________________________, proved to me through satisfactory evidence of identification, which were _______________________, to be the person whose name is signed above in my presence.

____
NOTARY PUBLIC (Seal or Stamp)

Mail the completed Release of Information Authorization, copy of identification (or properly notarized form) and any additional documentation as applicable to: **METALQUEST, INC., ATTN: SSHS - RELEASE OF INFORMATION DEPARTMENT, PO BOX 46364, CINCINNATI, OH 45246-0364.**

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