MetalQuest

Release of Information Form - Fayette Regional Health System

Read all information carefully.

General Information

MetalQuest, Inc. is the Custodian for Patient Health Records (medical records) for the Fayette Regional Health System. As the Custodian, MetalQuest maintains these records for Fayette Regional Health System formerly located in Connersville, Indiana. Records maintained by MetalQuest for the facilities listed above are for patients seen prior to July 16, 2019.

How to Request Patient Health Records

If you were a patient at the facility mentioned above prior to July 16, 2019, then please complete the Release of Information Authorization Form (included in this document) for Fayette Regional Health System in its entirety. Any records from this time period and prior will likely be filed at MetalQuest. 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: Fayette Regional 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 will be released in digital form and provided on an encrypted Windows USB drive or by secure electronic transfer..

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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 Fayette Regional Health System 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.

2. Any fee due is must be paid in advance to release the requested record. hy film.

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

Please note that MetalQuest will prepare and ship the complete Patient Health 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 Record	Labor - $20.00 First ten pages are $1.00 per each Pages 11 – 50 are $0.50 each Pages 51+ are $0.25 each A page = one side of a piece of paper
Special Handling Charges	$250.00 per hour for the first hour; $50.00 per hour for each additional hour plus postage or courier fee.
Records Certification Fee	$50.00 per certification
Shipping	The fee will determined according to shipping method.

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Upon receipt of invoice, send payment to:

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

Credit/debit cards are accepted.

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

PATIENT INFORMATION:

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

I hereby authorize MetalQuest, Inc, Custodian for the former Fayette Regional Health System, to release and disclose medical information to the recipient listed below. I have been a patient of Fayette Regional Health System or I am the Patient's Legally Authorized Representative. I understand that the Custodian 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:	
TELEPHONE NUMBER:	FAX NUMBER:
EMAIL: (Do not provide address if you do not wish to be contacted via email)	

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

<table>
<tr><td colspan="2">Type of Information to Be Released and Disclosed:
☐ Complete Patient Health Record (Medical Records)
☐ Date Range: _____ to _____
☐ Other:_____
(NOTE: MetalQuest will prepare and ship the complete Patient Health Record unless otherwise directed above. Please see the attached information sheets for fees.)</td></tr>
<tr><td>☐ Check if granting authorization to discuss health information</td><td>Include: (indicate by initialing)
_____ Alcohol/Drug Treatment
_____ Behavioral/Mental Health Information
_____ Genetic/Reproductive Rights Information
_____ Sexually Transmitted/Infectious Disease Information
_____ HIV-Related Information</td></tr>
<tr><td>Reason for Request:
☐ At the Request of the Individual
☐ Other_____</td><td>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_____</td></tr>
</table>

I fully understand that the information to be disclosed includes my/the patient's 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** only if I place my initials on the appropriate line above. In the event the health information described above includes any of these types of information, and I initial the line on the box above, I specifically authorize release of such information to the person(s) indicated above.

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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.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. However, MetalQuest is unable to release my records and/or pathology slides 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.

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

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PATIENT SIGNATURE:	DATE: (MM/DD/YYYY)
(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.)	
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 Patient's Legal Representative: For example, Guardianship, Executor of 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: FAYETTE REGIONAL RELEASE OF INFORMATION DEPARTMENT, PO BOX 46364, CINCINNATI, OH 45246-0364.**