

Read all information carefully.

General Information

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

How to Request Patient Health Records and Radiology Records

If you were a patient at St. Vincent 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: SVCMC 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

To obtain copies of all other portions of your Health Record, please contact:

Iron Mountain
Attn: Medical Records
448 Broadway
Ulster Park, NY 12487
Fax: 845-338-0206
Email: ROINYMetro@ironmountain.com

Format

Patient Health Records will be released in digital form and provided on a Windows CD/DVD.

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 St. Vincent Hospital - Manhattan 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.

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: SVCMC 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.

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:	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 St. Vincent Hospital - Manhattan, to release and disclose medical information to the recipient listed below. I have been a patient of St. Vincent 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:	
TELEPHONE 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: <input type="checkbox"/> Patient Health Record (Medical Records) <input type="checkbox"/> Radiology Records (X-Rays and other Radiology Tests) <input type="checkbox"/> 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: <input type="checkbox"/> Medical Treatment <input type="checkbox"/> Disability <input type="checkbox"/> Employer <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> At the Request of the Individual <input type="checkbox"/> Other _____	Send Release of Information Invoice To: <input type="checkbox"/> Patient listed above <input type="checkbox"/> Recipient listed above <input type="checkbox"/> Other Responsible Party listed below: Name/Organization _____ Street Address _____ City, State, Zip _____ Contact Name _____ Phone _____

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: SVCMC RELEASE OF INFORMATION DEPARTMENT, PO BOX 46364, CINCINNATI, OH 45246-0364.**