Read all information carefully.

General Information

MetalQuest, Inc. is the Trustee for Patient Health Records (medical records) for the Christus Santa Rosa Surgical Center. As the trustee, MetalQuest maintains these records for Christus Santa Rosa Surgical Center.

How to Request Patient Health Records

Patient: If you were a patient at Christus Santa Rosa Surgical Center, please complete the Release of Information Authorization Form (included in this document) for Christus Santa Rosa Surgical Center in its entirety. You must include a copy of any one of the following: your state issued ID, state driver's license or birth certificate.

Patient Representative: If you are a parent (requesting records for a minor child), legal guardian or other authorized patient representative, please complete the Release of Information Authorization Form (included in this document) for Christus Santa Rosa Surgical Center in its entirety and include a copy or your state issued ID or driver's license. In addition, attach all applicable documents of authority to support your claim of being the patient's legally authorized representative. For Example: Guardianship, Executor of Estate, Power of Attorney, Birth Certificate, Certificate of Death.

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

MetalQuest, Inc.
ATTN: Christus Santa Rosa Surgical Center Release of Information Department
PO Box 46364
Cincinnati, OH 45246-0364
Fax: 513-242-5059
Email: retrieve@metalquest.com

If you have questions about how to complete the form, MetalQuest can be reached at **513-898-1022** between the hours of 9:00 AM and 4:00 PM, eastern time zone. You may also contact us at the fax number or email address listed above.

Format

Patient Health Records can be released in the following ways: by Mail via Encrypted USB; by Email via Encrypted Download Link; by Facsimile Transmission (25 pages maximum); or by Mail via Paper Copy. We will make every effort to comply with your request.

Release Process

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

1. The request is received via submission of a properly completed MetalQuest Christus Santa Rosa Surgical Center Release of Information Authorization Form. Once received, the request is reviewed for required documentation and completeness. If we are able to fulfill your request, you will be notified of the fees required to complete the request. If we are unable to fulfill your request, you will be notified and additional information or documentation requested as applicable.
2. Payments may be made by check or money order and mailed to: **MetalQuest, Inc, Attn: Christus Santa Rosa Surgical Center Release of Information Department, PO Box 46364, Cincinnati, OH 45246-0364**.
3. Upon receipt of payment of any required fees, the records will be scanned and transmitted via your selected method.

Please note that MetalQuest will prepare the entire Patient Health Record unless otherwise directed on the Release of Information Authorization Form.

Fees

Description	Fee
Patient Health Records - Hardcopy	Retrieval Fee $45.79 - Includes first 10 pages $1.54/page for pages 11-60 $0.76/page for pages 61-400 $0.41/page for 401+ pages Actual cost of mailing or shipping
Patient Health Records - Microform	Retrieval Fee $69.74 - Includes first 10 pages $1.54/page for pages 11+ Actual cost of mailing or shipping
Patient Health Records - Electronic	Retrieval Fee $82.95 Actual cost of mailing or shipping
Patient Health Records - X-Rays and Diagnostic Imaging Studies	$8.00 per copy Actual cost of mailing or shipping
Special Handling Charges	$250.00 per hour $50.00 per hour for each additional hour Actual cost of mailing or shipping NOTE: The per page fee does not apply. For example, if a page by page review of the record is needed to exclude information from release. We will contact you in advance if these charges will apply.
Records Certification Fee	$50.00 per Certification Actual cost of mailing or shipping
Affidavit/Direct Questions	$250.00 Actual cost of mailing or shipping

Shipping

All records will be shipped or transmitted via the requested method. Under no circumstance will MetalQuest accept personal deliveries of Release of Information Authorization Forms or payments. Records may not be picked up in person at MetalQuest.

MetalQuest

Christus Santa Rosa Surgical Center
Patient Health Records ROI Form

COMPLETE ALL FIELDS – PLEASE TYPE OR PRINT CLEARLY

PATIENT INFORMATION:

PATIENT NAME: (Last, First, Middle)	DATE OF BIRTH: (MM/DD/YYYY)
MAIDEN NAME:	MEDICAL RECORD NUMBER: (If Known)
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 Christus Santa Rosa Surgical Center, to release and disclose medical information to the recipient listed below. I have been a patient of Christus Santa Rosa Surgical Center or I am the Patient's 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.)

NAME:	
ORGANIZATION NAME: (If applicable.)	
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 boxes and fill in fields applicable to this request.)

Type of Information to be Released and Disclosed: (Please check box.)

- Complete Patient Health Record (Medical Records)
- Radiology Records (X-Rays, Mammograms and other Radiology Tests)
- Radiology Records – Original Mammogram(s)
- Pathology Specimens (Laboratory Slides)
- Date Range: _____ to _____
- 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.)

DO NOT INCLUDE: (If you **DO NOT** want the following types of information released, indicate by checking the appropriate box.)

- ☐ Alcohol/Drug Treatment
- ☐ Behavioral/Mental Health Information
- ☐ Genetic/Reproductive Rights Information
- ☐ Sexually Transmitted/Infectious Disease Information
- ☐ AIDS and HIV-Related Information

Please indicate your preferred method of release below: (Please check box.)

- ☐ Mail Encrypted USB
- ☐ Email via Encrypted Download Link
- ☐ Facsimile Transmission (25 Pages Maximum)
- ☐ Mail via Paper Copy

Send Release of Information Invoice to: (Please check box.)

- Patient Listed Above
- Recipient Listed Above
- Other Responsible Party Listed Below

Name/Organization_____
Street Address_____
City, State, Zip_____
Contact Name _____Phone_____

Reason for Request: (Please check box.)

- At the Request of the Individual
- Other_____

MetalQuest

Christus Santa Rosa Surgical Center
Patient Health Records ROI Form

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** if I do not check the appropriate box in the "DO NOT INCLUDE" section of this Authorization. In the event the health information described above includes any of these types of information, and I do not check the appropriate box, I specifically authorize release of such information to the person(s) indicated.

If I am authorizing the release of any of the information set forth above, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the Texas Health and Human Services Commission, Complaint and Incident Intake at (888) 973-0022. This is the agency responsible for protecting my rights.

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 in reliance upon this Authorization. If I choose to revoke this Authorization, I must do so in writing to MetalQuest 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 redisclosure 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 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.

PATIENT SIGNATURE**:**	DATE: (MM/DD/YYYY)
Parent or Patient's Legally Authorized Representative Signature:	Printed Name, Address and Telephone Number of Parent or Patient's Legally Authorized 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 Legally Authorized Representative. For Example: Guardianship, Executor of Estate, Power of Attorney, Birth Certificate, Certificate of Death	

Mail the completed Release of Information Form, copy of identification and any additional documentation as applicable to: **METALQUEST INC, ATTN: SANTA ROSA SURGICAL CENTER RELEASE OF INFORMATION DEPARTMENT, PO BOX 46364, CINCINNATI, OH 45246-0364.** Alternately, your request may be faxed to **513-242-5059** or emailed to **retrieve@metalquest.com** .

