MetalQuest

CSC - Patient Health Records Release of Information Form

COMPLETE ALL FIELDS – PLEASE TYPE OR PRINT CLEARLY

PATIENT INFORMATION:

PATIENT NAME: (Last, First, Middle)	DATE OF BIRTH: (MM/DD/YYYY)	
ALIAS/AKA/NAME USED FOR SERVICE: (Last, First, Middle)	SOCIAL SECURITY NUMBER:	
ADDRESS:	TELEPHONE NUMBER:	FAX NUMBER:
	EMAIL: (Do not provide address if you do not wish to be contacted via email.)	

I hereby authorize MetalQuest, Inc, Trustee for the former Center for Specialty Care, Inc. (CSC) to release and disclose medical information to the recipient listed below. I have been a patient of CSC 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.)

NOTE: MetalQuest will automatically search for and release the entire patient health record across all CSC programs unless otherwise specified by completing the program information and/or the date range below. If program information is provided, patient records will be limited to the program specified. If you want only specific documents released, complete the Date Range, Program Information and Other sections as applicable and specify the documents in Other.

Type of Information to be Released and Disclosed:

Entire Patient Health Record (All programs/dates/documents.)

Date Range: _____ to _____

Other (Please Specify):_____

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 via CD/DVD Disk
- ☐ Email via Encrypted Download Link
- ☐ Facsimile Transmission (100 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_____

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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 redisclosing 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. I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

This Authorization will automatically expire in 120 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: (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 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: CSCNYC 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** .

