Read all information carefully.

General Information

MetalQuest, Inc. is the Records Custodian for Radiology Records (X-Rays, MRI, CAT Scan, Mammography and other radiology images and related reports) for Deaconess Health Association Inc. As the Records Custodian, MetalQuest maintains these records for Deaconess Health Association.

How to Request Raidology Records

Patient: If you were a patient at Deaconess Health Association, please complete the Release of Information Authorization Form (Included in this document) for Deaconess Health Association 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 Deaconess Health Association 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: Deaconess Health Association 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 Radiology Records can be released in the following ways: by Mail via Encrypted USB or by Email via Encrypted Download Link. 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 Deaconess Health Association 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: Deaconess Health Association 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 Radiology Record unless otherwise directed on the Release of Information Authorization Form.

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Fees

Description	Fee
Radiology Records - Patient or Patient Representative Request	X-Ray, MRI, Cat Scan or other Radiology Image: $2.27 per page Paper Report Copies: $3.31 for 1-10 pages; $0.69/page for 11-50 pages; $0.28/page for 51+ pages Plus Postage
Radiology Records - Third Party Request	Search Fee: $20.42 X-Ray, MRI, Cat Scan or other Radiology Image: $2.27 per page Paper Report Copies: $1.34/page up to 10 pages; $0.69/page for 11-50 pages; $0.28/page for 51+ pages Plus Postage

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.

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Deaconess Health Association Inc
Radiology 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)
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, Records Custodian for Deaconess Health Association Inc's radiology records to release and disclose my medical information to the recipient listed below. I have been a patient of Deaconess Health Association Inc or I am the Patient's Legally Authorized Representative. I understand that the Records Custodian 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.)

Entire Radiology Record (X-Rays, MRI, CAT Scan, Mammography and other radiology images and related reports)
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.)	**Please indicate your preferred method of release below:** (Please check box.)
☐ Alcohol/Drug Treatment ☐ Behavioral/Mental Health Information ☐ Genetic/Reproductive Rights Information ☐ Sexually Transmitted/Infectious Disease Information ☐ AIDS and HIV-Related Information	☐ Mail via Encrypted USB ☐ Email via Encrypted Download Link
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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Deaconess Health Association Inc
Radiology Records Release of Information 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 redisclosing such information without my authorization unless permitted to do so under federal or state law.

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: DEACONESS HEALTH ASSOCIATION 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** .

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