Read all information carefully.

General Information

MetalQuest, Inc. is the Trustee for the electronic portions of Mt. Vernon Hospital's Patient Health Records (medical records) and Radiology Records (x-rays and other radiology tests) formerly located in Mt. Vernon, NY. As the Trustee, MetalQuest maintains these records for Mt. Vernon Hospital.

How to Request Patient Health Records and Radiology Records

If you were a patient at Mt. Vernon 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. If you are a Parent (requesting records for a minor child), Legal Guardian or other Authorized Patient Representative, please follow the additional instructions located directly on the Release of Information Authorization Form in addition to sending a copy or your State Issued ID or Driver's License.

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

MetalQuest, Inc.
ATTN: Mt. Vernon Hospital 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 can be released in the following ways:

- ☐ Digitally via CD/DVD Disk
- ☐ Via Encrypted Download Using an Email Link
- ☐ Via Facsimile Transmission (100 pages or less)

Radiology Records can be released in the following ways:

- ☐ Digitally via CD/DVD Disk
- ☐ Via Encrypted Download Using an Email Link

Please indicated your preferred method of release by checking the applicable box(es) above and return a copy of this page with your authorization form. 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 Mt. Vernon Hospital Release of Information Authorization form. The completed form can be delivered to MetalQuest by one of four methods: email, fax, USPS or courier. 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 directed to: **MetalQuest, Inc, Attn: Mt. Vernon Hospital Release of Information Department, PO Box 46364, Cincinnati, OH 45246-0364**.
3. Upon receipt of payment of any required fees, the records will be transmitted via your selected method.
4. The request data and logging information 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.

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

MT. VERNON HOSPITAL - MT. VERNON
Release of Information Authorization

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:
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, Trustee for the former Mt. Vernon Hospital, Mt. Vernon, NY, to release and disclose medical information to the recipient listed below. I have been a patient of Mt. Vernon Hospital 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)

FULL NAME:	
ORGANIZATION NAME:	
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 blocks and fill in fields applicable to this request)

Type of Information to be Released and Disclosed:

- ☐ Complete Patient Health Record (Medical Records)
- ☐ Complete Radiology Records (X-Rays and other Radiology Tests)
- ☐ Date Range: _____ to _____
- ☐ Other (Please Specify):_____

(**Note:** MetalQuest will prepare and ship the complete Patient Health Record and/or Radiology Records unless otherwise directed above and below.)

DO NOT INCLUDE: (If you do not want the following types of information released, indicate by initialing the appropriate line.) _____Alcohol/Drug Treatment _____Behavioral/Mental Health Information _____Genetic/Reproductive Rights Information _____Sexually Transmitted/Infectious Disease Information _____AIDS and HIV-Related Information	☐ Check if granting authorization to discuss health information
Send Release of Information Invoice to: ☐ Patient Listed Above ☐ Recipient Listed Above ☐ Other Responsible Party Listed Below Name/Organization_____ Street Address_____ Cit, State, Zip_____ Contact Name _____Phone_____	**Reason for Request:** ☐ At the Request of the Individual ☐ Other_____

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 place my initials on the appropriate line on the first page of this authorization. In the event the health information described above includes any of these types of information, and I do not initial the appropriate line in the check box on the first page of this authorization, I specifically authorize release of such information to the person(s) indicated (Recipient).

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 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 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	

Mail the completed Release of Information Authorization, copy of identification and any additional documentation as applicable to: **METALQUEST INC, ATTN: MT VERNON HOSPITAL RELEASE OF INFORMATION DEPARTMENT, PO BOX 46364, CINCINNATI, OH 45246-0364.**

