

Read all information carefully.

General Information

MetalQuest, Inc. is the Trustee for Human Resource Records (employment records) for the Sound Shore Medical Center. As the Trustee, MetalQuest maintains these records for the Sound Shore Medical Center.

How to Request Human Resource Records

If you were an employee of the Sound Shore Medical Center and copies of records are needed, please complete the Release of Information Form (included in this document) for the Sound Shore Medical 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.

Mail, fax or email the completed form and copy of identification to:

MetalQuest, Inc.
ATTN: Sound Shore Medical Center
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.

If **verbal verification only** is needed for Name, Title and Dates of Employment please call **513-898-1022** between the hours of 9:00 AM and 4:00 PM, eastern time zone.

Format

Human Resource 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 Sound Shore Medical Center Release of Information 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: Sound Shore Medical 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 complete Human Resource Record unless otherwise directed on the Release of Information Form.

Fees

The following fees are charged for processing the Release of Information Authorization.

Description	Fee
Human Resource/ Credentialing Records Reproduction Fee	\$1.00 per page plus postage or courier fee. (For example: 50 Pages is \$50.00 plus postage; 100 pages is \$100.00 plus postage; 200 pages is \$200.00 plus postage)
Shipping Format	Via Digitally Encrypted USB \$30.00 Via Encrypted Download Using an Email Link \$10.00 Via Facsimile Transmission \$10.00 (25 pages maximum) Via Paper Copy \$0.25/page additional
Expediting Services	Same Day \$100.00 Next Day \$75.00 One to Five Days \$50.00 Two Weeks \$25.00 30 Days \$0.00
Special Handling Charges	\$75.00 per hour plus postage or courier fee. The \$1.00 per page fee does not apply. (This fee only applies if special handling of your record is needed. We will contact you in advance if these charges will apply.)
Records Certification Fee	\$50.00 per certificate
Minimum Reproduction Fee	\$50.00 not including shipping
Shipping	\$10.00 minimum

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.



**Sound Shore Medical Center - Human Resources
Release of Information Form**

COMPLETE ALL FIELDS – PLEASE TYPE OR PRINT CLEARLY

EMPLOYEE INFORMATION:

EMPLOYEE NAME: (Last, First, Middle)	DATE OF BIRTH: (MM/DD/YYYY)	
ALIAS/AKA/NAME: (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 Sound Shore Medical Center, to release and disclose my employment information to the recipient listed below. I understand that the Trustee has confidential employment information about me.

RECIPIENT INFORMATION: (Information will be sent to the person listed below.)

NAME:		
ORGANIZATION NAME: (If applicable.)		
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:	
Entire Human Resource Record Date Range: _____ to _____ Other (Please Specify): _____	
Send Release of Information Invoice to:	Please indicate your preferred method of release below:
Employee Listed Above Recipient Listed Above Other Responsible Party Listed Below Name/Organization _____ Street Address _____ City, State, Zip _____ Contact Name _____ Phone _____	<input type="checkbox"/> Mail via Digitally Encrypted USB <input type="checkbox"/> Email via Encrypted Download Link <input type="checkbox"/> Facsimile Transmission (25 Pages Maximum) <input type="checkbox"/> Mail via Paper Copy

I fully understand that the employment information to be disclosed may include my entire employment history, including dates of employment, wages and any information relative to my employment, employment applications and other related matters unless otherwise specified above.

I further release MetalQuest, Inc. from any and all liability of any kind for releasing any employment information and agree to indemnify and hold MetalQuest harmless for the release of same.

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 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.

EMPLOYEE SIGNATURE:	DATE: (MM/DD/YYYY)
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Mail the completed Release of Information Form and copy of identification to: **METALQUEST INC, ATTN: SOUND SHORE MEDICAL 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.