Release of Information Form – Bay Area Regional Medical Center

Dear Requestor:

Thank you for requesting your medical records from the former Bay Area Regional Medical Center. In order to fulfill your request records, please complete the attached Release of Information Form and return it.

Need Faster Service and Want to Save a Stamp?

Rather than manually completing the form, the form can be completed and submitted via the internet by going to

https://metalquest.com/barmct

At the bottom of the form, payment information can be entered. Entering your payment information will help speed the delivery of your chart. If the fee is more than the amount selected, then you will be contacted, before any charge to your credit/debit card or checking/savings account is made unless authorized otherwise.

Lastly, the form is seven pages. Please carefully read and complete each page, as necessary.

Please do not hesitate to contact us Monday – Friday, 8:00 A.M. to 5:00 P.M.

Telephone Number: 513-898-1022

Fax Number: 513-242-5059

Email: Retreive@MetalQuest.com

Sincerely,

MetalQuest Trust Team

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Read all information carefully.

General Information

MetalQuest, Inc. is the Custodian for Patient Health Records (medical records) for the Bay Area Regional Medical Center. As the Custodian, MetalQuest maintains these records for The Bay Area Regional Medical Center formerly located in Webster, Texas.

How to Request Patient Health Records

If you were a patient at the facility mentioned above, then please complete the Release of Information Authorization Form (included in this document) for Bay Area Regional Medical Center in its entirety. Any records from this time period and prior will likely be filed at MetalQuest. You (the patient) must include a copy of any one of the following: your State Issued ID, State Driver's License, or Birth Certificate. Your notarized signature is acceptable in place of the State ID, Driver's License or Birth Certificate. If you are a Parent (requesting records for a minor child), Legal Guardian or other Patient Representative, please follow the additional instructions located directly on the Release of Information Authorization Form in addition to sending a copy of your State Issued ID or Driver's License. Your notarized signature is acceptable in place of the State ID or Driver's License.

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

MetalQuest, Inc.
ATTN: BARMC 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 will be released in digital form and provided on an encrypted Windows USB drive, by secure electronic transfer or paper copy.

Release Process

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

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1. The request is received via submission of a properly completed MetalQuest Bay Area Regional Medical Center Release of Information Authorization form. The form may be obtained at **www.metalquest.com/MQInnerTrust.html**. The completed form should be delivered to MetalQuest by one of four methods: email, fax, USPS or courier. The original request is imaged and archived and is data-entered in our database using a unique Request ID number. The request is vetted for required documentation.

2. Any fee due is must be paid in advance to release the requested record.

3. The request data and logging pertaining to it are archived for the life of the Custodianship.

Please note that MetalQuest will prepare and ship the complete Patient Health Record unless otherwise directed on the Release of Information Authorization Form. If only specific information or portion of the record(s) is requested, special handling charges apply.

Fees

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

Description	Fee
Electronic Record	$88.36
Special Handling Charges	$250.00 per hour for the first hour; $50.00 per hour for each additional hour plus postage or courier fee. The $0.75 per page fee does not apply.
Records Certification Fee	$50.00 per certification
Shipping	The fee will be determined according to shipping method.
Affidavit/Direct Questions	$250.00

Upon receipt of invoice, send payment to:

MetalQuest, Inc.
ATTN: BARMC Release of Information Department
PO Box 46364
Cincinnati, OH 45246-0364

Credit/debit cards are accepted.

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Shipping

All records will be shipped. Under no circumstances will MetalQuest accept personal deliveries of Release of Information Authorization Forms, payments or arrangements for pickup at MetalQuest.

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COMPLETE ALL FIELDS – DO NOT SIGN A BLANK FORM - PLEASE PRINT OR TYPE CLEARLY

PATIENT INFORMATION:

PATIENT NAME: (Last, First, Middle)	DATE OF BIRTH: (MM/DD/YYYY)
MAIDEN NAME:	MEDICAL RECORD NUMBER(S):
ADDRESS:	TELEPHONE NUMBER:
EMAIL: (Do not provide an address if you do not wish to be contacted via email)	FAX NUMBER:

I hereby authorize MetalQuest, Inc., Custodian for the former Bay Area Regional Medical Center, to release and disclose medical information to the recipient listed below. I have been a patient of Bay Area Regional Medical Center or I am the Patient's Legally Authorized Representative. I understand that the Custodian 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:	
TELEPHONE NUMBER:	FAX NUMBER:
EMAIL: (Do not provide an address if you do not wish to be contacted via email)	

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INFORMATION TO BE RELEASED: (Check blocks and fill in all fields applicable to this request)

Type of Information to Be Released and Disclosed: ☐ Complete Patient Health Record (Medical Records) ☐ Date Range: _____ to _____ ☐ Other:_____ (**NOTE:** MetalQuest will prepare and ship the complete Patient Health Record unless otherwise directed above. Please see the attached information sheets for fees.)	
Format and Shipping Instructions	Patient Health Records can be sent in the following ways, depending on the nature of the record. ☐ Via Digitally encrypted USB ☐ Via Encrypted download using an email link ☐ Via Facsimile Transmission (25 Pages or less) ☐ Via Paper Copy ($0.25 extra per page) Please check the box next to your preferred method. We will make every effort to comply with your choice if possible. Diagnostic images cannot be sent via fax.
Reason for Request: ☐ At the request of the Individual ☐ Other_____	**Send Release of Information Invoice To:** ☐ Patient listed above ☐ Recipient listed above ☐ Other Responsible Party listed below: Name/Organization_____ Street Address_____ City, State, Zip_____ Contact Name_____ Phone_____

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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 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, Inc. in reliance upon this authorization. If I choose to revoke this authorization, I must do so in writing to MetalQuest, Inc. 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 re-disclosure and the information may not be protected by federal health information privacy regulations if the recipient(s) described in 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 and/or pathology slides 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.

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PATIENT SIGNATURE:	DATE: (MM/DD/YYYY)
(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.)	
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	
State of _____ County of _____ On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed above in my presence. _____ NOTARY PUBLIC (Seal or Stamp)	

Mail the completed Release of Information Authorization, copy of identification (or properly notarized form) and any additional documentation as applicable to: **METALQUEST, INC., ATTN: BARMC RELEASE OF INFORMATION DEPARTMENT, PO BOX 46364, CINCINNATI, OH 45246-0364.**

Please indicate below if you would like your request to be expedited. We will do our

best to adhere to your request.

☐	**$100.00**	**Same Day Service**
☐	**$75.00**	**Next Day**
☐	**$50.00**	**One to Five Days**
☐	**$25.00**	**Two Weeks**
☐	**$0.00**	**30 Days**

Payment Information

Upon receipt of invoice, send payment to:

MetalQuest, Inc.
ATTN: FAYETTE REGIONAL Release of Information Department
PO Box 46364
Cincinnati, Ohio 45246-0364

Credit and Debit Card are also accepted. Please enter your information below to expedite the process.

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Due to the number of pages in your record, or distribution methods, the cost associated with a release in records can vary. **The average cost associated with a request from Fayette Regional Health is approximately $75.** Please indicate below how much you would like to authorize MetalQuest to charge to your card or account. If the amount is higher than what you indicated, we will contact you before we proceed.

- ☐ **I authorize MetalQuest to charge me any amount for my records**
- ☐ **I authorize MetalQuest to charge me if my bill is less than $30**
- ☐ **I authorize MetalQuest to charge me if my bill is less than $50**
- ☐ **I authorize MetalQuest to charge me if my bill is less than $75**
- ☐ **Please contact me before you make any charges**

Please indicate the best place to reach you and we will get in touch shortly.

Telephone_____ **Email_____**

Card Information

Name on Card _____

Card Number _____

Expiration Date _____ **CSC _____**

Street Address _____

City _____ **State_____**

Zip Code_____

*****Please Sign on Next Page*****

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Bank Information

If you would like to pay through your bank account, please include your information below

Name on the Account _____

Bank Name _____ **Phone #_____**

Account Type:

- ☐ Personal Checking Account
- ☐ Business Checking Account
- ☐ Savings Account
- ☐ Money Market Account
- ☐ Other _____

Routing Number_____

Account Number _____

Please sign here to authorize MetalQuest to withdraw the required funds from my account as I have indicated above:

Signature _____ **Date_____**