



Release of Information Form – Little River Healthcare

Read all information carefully.

General Information

MetalQuest, Inc. is the Custodian for Patient Health Records (medical records) for the Little River Healthcare, et al. As the Custodian, MetalQuest maintains these records for Little River Healthcare, et al with facilities formerly located in Bastrop, Cameron, Georgetown, Rockdale, Salado and Temple, Texas. (See facility list on last page.) Records maintained by MetalQuest for the facilities listed above are for patients seen prior to December 8, 2018.

How to Request Patient Health Records

If you were a patient at the facility mentioned above prior to December 8, 2018, then please complete the Release of Information Authorization Form (included in this document) for Little River Healthcare, et al 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 Drivers 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: LRH 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
Secure 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 or by secure electronic transfer.



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Release Process

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

1. The request is received via submission of a properly completed MetalQuest Little River Healthcare, et al 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; \$75.00 per hour for each additional hour plus postage or courier fee
MetalQuest Records Certification Fee	\$50.00 per certification
Completion of Client Provided Documents	\$250.00 per document
Shipping	The fee will determined according to shipping method.



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Upon receipt of invoice, send payment to:

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Cincinnati, OH 45246-0364

Credit/debit cards and e-Checks are accepted.

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 address if you do not wish to be contacted via email)	FAX NUMBER:

I hereby authorize MetalQuest, Inc, Custodian for the former Little River Healthcare, et al, to release and disclose medical information to the recipient listed below. I have been a patient of Little River Healthcare, et al 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 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)

<p>Type of Information to Be Released and Disclosed:</p> <p><input type="checkbox"/> Complete Patient Health Record (Medical Records)</p> <p><input type="checkbox"/> Date Range: _____ to _____</p> <p><input type="checkbox"/> Other: _____</p> <p>(NOTE: MetalQuest will prepare and ship the complete Patient Health Record unless otherwise directed above. Please see the attached information sheets for fees.)</p>	
<p><input type="checkbox"/> Check if granting authorization to discuss health information</p>	<p>Include: (indicate by initialing)</p> <p>____ Alcohol/Drug Treatment</p> <p>____ Behavioral/Mental Health Information</p> <p>____ Genetic/Reproductive Rights Information</p> <p>____ Sexually Transmitted/Infectious Disease Information</p> <p>____ HIV-Related Information</p>
<p>Reason for Request:</p> <p><input type="checkbox"/> At the Request of the Individual</p> <p><input type="checkbox"/> Other _____</p>	<p>Send Release of Information Invoice To:</p> <p><input type="checkbox"/> Patient listed above <input type="checkbox"/> Recipient listed above</p> <p><input type="checkbox"/> Other Responsible Party listed below:</p> <p>Name/Organization _____</p> <p>Street Address _____</p> <p>City, State, Zip _____</p> <p>Contact Name _____ Phone _____</p>

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** only if I place my initials on the appropriate line above. In the event the health information described above includes any of these types of information, and I initial the line on the box above, I specifically authorize release of such information to the person(s) indicated above.



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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 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 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:	
<p>Attach All Applicable Documents of Authority to support your claim of being the Patient’s Legal Representative:</p> <p>For example, Guardianship, Executor of Estate, Power of Attorney, Birth Certificate, Certificate of Death</p>		
<p>State of _____</p> <p>County of _____</p> <p>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.</p>		
_____ 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: LRH RELEASE OF INFORMATION DEPARTMENT, PO BOX 46364, CINCINNATI, OH 45246-0364.**



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The Little River Healthcare facilities listed are in alphabetical order with an address, as they were known in the community.

Bastorp Imaging

Suite 108
3101 Highway 71 East
Bastrop, TX 78602

King's Daughters Imaging Center

1905 SW H K Dodgen Loop
Temple Texas 76502

Cameron Hospital

806 North Crockett Avenue
Cameron, Texas 76520

Rockdale Hospital

1700 Brazos Avenue
Rockdale, Texas 76567

Cameron Clinic

806 North Crockett Avenue
Cameron, Texas 76520

Rural Health Care Clinic/Downtown Clinic

602 N Main Street
Rockdale, Texas 76567

Family Care Center A

1700 Brazos Avenue
Rockdale, Texas 76567

Salado Clinic

Salado, Texas

Family Care Center B

1700 Brazos Avenue
Rockdale, Texas 76567

Temple Imaging Center

1905 Southwest H K Dodgen Loop
Temple Texas 76502

Georgetown Imaging

1528 Leander Road
Georgetown, Texas 78628

Temple Surgery Center

1905 Southwest H K Dodgen Loop
Temple Texas 76502