MetalQuest

The Silver Lining in Records Management

Release of Information Form – Oral & Maxillofacial Surgery Associates, PLLC

Read all information carefully.

General Information:

MetalQuest, Inc. is the Custodian for Patient Health Records for **Oral & Maxillofacial Surgery Associates, PLLC** As the Custodian, MetalQuest maintains these records for **Oral & Maxillofacial Surgery Associates, PLLC**, formerly located in Shalimar, Florida. Records maintained by MetalQuest for the facilities listed above are for patients seen prior to September 15, 2026.

Former Locations:

Okaloosa County

7 Clifford Drive
Shalimar, Florida 32579

Available Records:

MetalQuest, Inc. holds records from Oral & Maxillofacial Surgery Associates, PLLC, from September 15, 2026, and prior. Available records include medical records and imaging records.

If you need records that are not referenced above, please contact our office for assistance. Please note: the retention period for Oral & Maxillofacial Surgery Associates, PLLC is for a minimum of 5 years from the date of the last patient contact. For minors, records must be kept for 6 year after the patient reaches the age of majority (18). Records outside of this retention period may not be available.

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Fees:

The following fees are charged for processing the release of information authorization. These fees are subject to change and may vary based on the state-regulated fee schedule. Any submitted prepayment will be applied to the total cost of service. All fees are payable in advance.

Florida Administrative Code Rule 64B8-10.003, Florida State Statutes 395.3025

Description	Fee
Medical Record	Physical Records: Pages 1-25: $1.00 per page Pages 26 +: $0.25 per page Electronic Records: $2.00 per page First Party Prepayment: $11.00 Third Party Prepayment: $21.00 *A page = one side of a piece of paper* Fee subject to change based on state recommended updates
Radiology Records (x-rays)	Actual Cost of Reproduction
Special Handling Charges (Ex: Record redaction and specialty searches. Applies mostly to third party requestors)	$250.00 per hour for the first hour; $125.00 per hour for each additional hour plus postage or courier fee.
Shipping	the actual cost of mailing, shipping, or otherwise delivering the provided copies.

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How to Request Patient Health Records:

If you were a patient at the facility mentioned above prior to September 15, 2026, then please complete the Release of Information Authorization Form for Oral & Maxillofacial Surgery Associates, PLLC, 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 for in addition to sending a copy of your *State Issued ID, or Driver's License*.

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

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

Format:

Patient Health Records will be released in digital form and provided on an encrypted USB drive, by secure electronic transfer or paper copy. X-rays and mammograms can be released only in digital format. Hardcopy is not available.

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

1. The request is received via submission of properly completed MetalQuest Oral & Maxillofacial Surgery Associates, PLLC Release of Information Authorization form. The form may be obtained at www.MetalQuest.com. The completed form should be delivered with prepayment by one of five methods: online e-form submission, 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, and the prepayment is processed.
2. Confirmation to pull located documents must be received prior to the pulling of records. Any fee due 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.
4. 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, then special handling charges apply.
5. All records will be shipped or transmitted via the requested method. 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 review the following prior to submitting a request. I hereby authorize MetalQuest, Inc., Custodian, for Oral & Maxillofacial Surgery Associates, PLLC, to release and disclose medical information to the recipient listed below. I have been a patient of Oral & Maxillofacial Surgery Associates, PLLC 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.

Patient Information:

Patient Name: (last, first, middle) *required		Alternate Name:	
Date of Birth (mm/dd/yyyy) *required		Social Security Number:	
Patient Street Address:	City:	State:	Zip Code:
Patient Phone:	Patient Email:		Patient Fax:
Prefers to be contacted by: ○ Phone ○ Email *recommended		Reason for release of information: ○ At the request of the individual ○ Legal ○ Medical ○ Other:	

Information to be Released:

Note: MetalQuest will prepare and ship the complete Patient Health Record unless otherwise directed below. Please see the information at the top of this form for fees. **Requests for more than one record type will be processed as separate requests. Prepayments are required for each request.**

- ○ Medical
- ○ Billing
- ○ Other:
- ○ Dates of service: _____ to _____

Any pertinent information:

Do Not Include:

Initials required

Note: additional fees may apply for redaction.

___ Alcohol/drug treatment

___ Behavioral/mental health information

___ Genetic/reproductive rights information

___ AIDS/HIV related information

Information Format and Shipping:

Patient Health Records can be sent in the following ways, depending on the nature of the record. Please check the box next to your preferred method. We will make every effort to comply with your choice if possible. Please be sure to include all necessary shipping information for the chosen method. Diagnostic images/X-rays can be delivered in digital format only. They cannot be sent via fax or printed.

- ○ Via digitally encrypted USB ($60.00)
- ○ Via encrypted download using an email link ($10.00) *recommended
- ○ Via facsimile transmission (25 pages or less, $15.00)
- ○ Via paper copy ($0.35 additional per page cost plus postage)

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Recipient Information:

- Patient is recipient, address is the same as above
- Patient is not recipient, or address is not the same as above listed (please complete section below)

<table>
<tr><td>Organization Name:</td><td colspan="2">Direct Contact Name:</td></tr>
<tr><td rowspan="2">Street Address: _____
City: _____
State: _____
Zip Code: _____</td><td>Organization Number:</td><td>Direct Contact Number:</td></tr>
<tr><td>Fax Number:</td><td>Email:</td></tr>
<tr><td colspan="3">Prefers to be contacted by:
◯ Email *recommended ◯ Phone</td></tr>
</table>

Authorization to Release Records:

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.**

This authorization will automatically expire in 180 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.

Patient Signature:	Date: (MM/DD/YYYY)

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(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: Name:
Description of Authority to Act on Behalf of Patient:	Address: Telephone Number:
Reason Patient is Unable to Sign:	
Please attach proof of identity or any 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, etc.	

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: Release of Information Department
Po Box 46364
Cincinnati, OH 45246-0364

Fax the documents to: **513-242-5059**

Or, Email a copy to: **Retrieve@MetalQuest.com**

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 Day
- $25.00 Two Weeks
- $0.00 30 Days

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Billing: To improve processing time, please enter billing information below. This is not required. Please review the applicable fees for your request in the Facility General Information section. If you choose not to fill out this section, you will receive a invoice at your billing email address or physical billing address.

Credit/Debit Card Information:

Name on Card:	Card Number:
Expiration Date:	CSC:

Bank Information:

Name on the Account:	Bank Name:
Phone Number:	Account Type:
Routing Number:	Account Number:

By signing here, I authorize MetalQuest to charge the required amount to my credit/debit card, or to withdraw the required funds from the bank account that I have indicated above. I also confirm that I have read the prepayment agreement and understand the terms and conditions that apply when submitting a request to MetalQuest.

Signature _____ **Date** _____