

INSTRUCTIONS AND INVOICING INFORMATION

Please complete this form and mail to the location where you are treated. Upon receipt of this form, within 14 business days we will notify you of the completion of your request, and the total amount that is due.

At that time you may make payment over the telephone, or indicate that you would like to pick up records and make payment at that time.

Records will be mailed to a requested party upon receipt of payment for those records.

Please be advised that we require payment for records and films as outlined below:
Notes \$. 75 per page X-Rays \$ 5.00 ea MRI \$10.00 ea Disability Forms \$ 5.00 ea

We accept Cash, Check, Visa, Mastercard, and American Express

Office Locations:

5719 Widewater Parkway, Dewitt, NY 13214

5000 West Seneca Turnpike, Syracuse, NY 13219

4888 West Taft Road, Liverpool, NY 13088

5700 West Genesee Street Camillus, NY 13031

5100 West Taft Road, North Medical Center, Liverpool, NY 13090

4115 Medical Center Drive, Northeast Medical Center, Fayetteville, NY 13066

*** FOR OFFICE USE ONLY *****

Total Amount Due: _____

Amount Received: _____

Date Received: _____

Important Notice:

By Law, the information we disclose to you is confidential. You are responsible to protect the confidential nature of this information by destroying the enclosed copies after your stated purpose has been fulfilled. State Law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Disclosure of confidential HIV information that occurs as a result of general authorization for the release of medical information will be in violation of state law and may result in a fine or jail sentence or both. 10 N.Y.C.R.R. Part 63.5, Section 2786 of the Public Health Law.