

First Choice

Scanning & Copy Services

1490 William Floyd Parkway

Suite 105

Shirley, NY 11967

Phone: 631-345-9000

Fax: 631-345-3336

E-mail: Firstchoice1490@gmail.com

Dear Patient,

First Choice Scanning & Copy Services will be handling your request for copies of your medical records. Attached is the release form that **MUST** be completed in order for us to process your request. It is imperative that you fill out **every** line of this authorization in order for us to process your request in a timely manner (including **full** addresses); missing information could delay your request.

****There is a fee of \$0.75 per page, so please be specific in what you are requesting. ****

Once payment is received your file will then be mailed out.

If you have any questions regarding how to fill this form out please feel free to contact us.

Thank you,

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Instructions on filling out your Medical Records Authorization form and scheduling to **pick them up** @ Huntington Medical Group

Copy Services hours of operation:
Monday – Thursday 8:30am-5:00pm
Friday CLOSED

Out to lunch from 12 noon to 1pm

****Excluding Holidays****

P: 631-425-3816 F: 631-425-2222

****YOUR AUTHORIZATION FORM MUST BE FILLED OUT COMPLETELY AND SIGNED BY THE PATIENT****

If you would like to pick your records up, you **MUST** write PATIENT PICK UP on the top of your authorization form. We will call you when your records are ready to schedule a time for you to pick them up. There is a fee of **0.75 per page**, which must be paid at the time of pick up by either exact cash or check (written out to First Choice Scanning & Copy Services). We **do not** fax records to patients.

****Please note if you come to pick your records up Monday thru Friday between the hours of 12 noon and 1 p.m., after 4:30 p.m. or anytime on Saturday you will NOT be able to pick them up without having made prior arrangements with First Choice Scanning & Copy Services to have the records left at the (East entrance) information desk. The staff at the front desk **does not** have access to your records, so please make sure you have made arrangements with the Copy Service. ****

If you are sending someone else to pick up your records that person **MUST** have a letter signed by you (the patient) stating that you give them permission to pick your records up. They must also have picture ID. Without picture ID and a letter we will **NOT** release your records.

****If you would like to have your records transferred to another doctor's office you must make sure you fill out all of that other doctors information on your release form. Leaving any information out may prolong your records being sent. ****

****Please Note: The copy service can only release Radiology and Lab written results **after** the referring doctor (if from Huntington Medical Group) has given you your results. Please do not request them before you have received your results.****

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____ SS#: _____

Phone# Day: () _____ Eve: () _____

THIS SECTION MUST BE COMPLETELY FILLED OUT

I hereby authorize the Huntington Medical Group, PC to release my medical records

FROM DOCTOR:

TO:

NAME

NAME

STREET ADDRESS

STREET ADDRESS

CITY/STATE/ZIP

CITY/STATE/ZIP

WHAT RECORDS SHOULD BE RELEASED?

WHAT DATE RANGE SHOULD BE RELEASED? - FROM _____ TO: _____

ARE YOU LEAVING THE GROUP? _____

If the requested portion of the record contains information pertaining to drug, psychiatric or alcohol treatment or contains HIV related information, you must specifically consent to the release of such information by initialing both of the following:

Please initial

_____ I understand that if my records contain information concerning drug, alcohol treatment, or psychiatric treatment, such information will be released pursuant to this consent form.

_____ I understand that if my records contain confidential HIV related information; such information will be released pursuant to this consent form. Confidential HIV related information is any information indicating that a HIV test was done, HIV virus is present, HIV related illness or AIDS, or any other information which would indicate that a person has been potentially exposed to HIV.

_____ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

This consent will expire in 90 days.

The recipient of this information is not authorized to disclose this information from this patient's medical record to any other person facility without written authorization to do so.

PATIENT SIGNATURE DATE

PATIENT/GUARDIAN SIGNATURE DATE

WITNESS'S SIGNATURE DATE