NORTHCOURT PEDIATRICS

Kirsten P. Magowan MD, PC * Cynthia A Steinem MD
7278 Buckley RD * North Syracuse NY 13212
(315)-452-1712 * FAX (315)-452-0394

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I authorize Kirsten P. Magowan MD and/or Cynthia A. Steinem MD to use and disclose a copy of the specific health and medical information described below regarding:

Patient_____Birthdate _____

consisting of (check one:

- ❑ **Standard Summary: Last Well Exam, Complete Immunization record, growth chart, visit record summary, problem list, medication list, referral list. I understand that if my account is paid up there is no charge the first time I request a summary of records otherwise there is a charge of $0.75 per copied page for all requested records.**

- ❑ **Doctor's complete Medical Record for this patient. I understand that there is a charge of $0.75 per copied page any time I request complete medical records. By selecting this option I agree to pay this fee. Initials_____Date: _____**

➢ **Include mental health records ☐ Yes ☐ No Include Alcohol/drug abuse treatment records ☐ Yes ☐ No**

SEND RECORDS TO: (Name of Recipient Or Class of Recipients) _____

*Address*_____

_____

Phone _____ *Fax* _____

for the purpose of:

Patient transferring medical care to new doctor.

Reason for transfer(optional) _____

_____

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.
Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

➢ Unless otherwise indicated this authorization permits faxing of information to the above recipient.
❑ Faxing not permitted if this box is checked.

Patient or Patient's Legal Representative (Please Print) _____
(Patients 18 years and older must sign for themselves unless other specific legal authority has been granted)

Signature _____Date: _____

*Address*_____

_____*Phone* _____

Description of Representative's Authority (e.g. "Parent", "legal guardian", etc.) _____

Office use only: Date received:_____

Family Balance:_____Insurance Balance:_____Pending Claims:_____Debt Ack on file: _____