



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 (**Doctor's name**): _____

Address _____

Phone _____ Fax _____

to use and disclose a copy of the specific health and medical information described below regarding:

Patient _____ Birthdate _____

consisting of:

Growth Charts, Newborn History, Newborn Screen, Last Physical, Immunization/Lead/CBC record, Problem List, Medication List, Summary list of visits and referrals.

To: 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

For the purpose of transferring patient's 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.) _____