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

Your child has been referred for counseling services. Below is a list of providers for you to contact for an appointment for your child. Also attached are release of information forms for us to be able to discuss treatment and send/receive records – we ask that you complete these forms as soon as you get a counselor/psychiatrist established for your child and return them to our office so that we can provide your child's records in a timely manner. If we do not hear from you in one week, we will contact you to ensure that you are not having any problems in establishing care for your child and to provide any necessary assistance.

If you have any questions or concerns, please call our office at 315-452-1712.

Recommended Counseling Services

St. Joseph's Behavioral Health Care (Child & Youth Health):
North Med (Link) location 315-458-6111
James St location 315-703-2800

Family Services 315-451-2161

Brownell Center (Liberty Resources)..... 315-472-4471

Psychological Healthcare 315-452-2450

Bright Path Counseling Center 315-458-0919

Upstate Child & Adolescent Psychiatry 315-464-5540
(ask for Child psychiatry for counseling)

Kelly Hamilton, LMHC 315-401-7756

Play Therapy:
Lisa Clancy (Liverpool) 315-451-2522
Juanita Mitchell (Fayetteville) 315-569-1968

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

- Patient _____Birthdate _____

I hereby authorize 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

to disclose to or receive from the individual/organization below, the specific health and medical information described below:

- Extent of Authorization CHECK a. b. or c. below

a. ☐ *I authorize the release/receipt of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).*
OR

b. ☐ *I authorize the release/receipt of my complete health record with the exception of the following information:*

☐ *Mental health records* ☐ *Alcohol/drug abuse treatment*

☐ *Other (please specify):* _____

c. ☐ ***The following specific information*** _____

_____

- This authorization for release/receipt of information covers the period of healthcare from:

a. ☐ _____ *to* _____
OR

b. ☐ *all past, present, and future periods.*

RELEASE/RECEIVE INFORMATION TO/FROM:

- Individual/organization: _____
- Address _____

_____

Phone _____ ***Fax*** _____

- . ☐ (Address and/or fax # may be obtained at time of request for information)

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

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 shall remain in effect upon completion of services or treatment.**

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.)* _____