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 RELEASE/RECEIVE copies of 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.)* _______________________________