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 FOR SCHOOL OR DAYCARE

I authorize Kirsten P. Magowan MD and/or Cynthia A. Steinem MD to disclose to or receive from the school and/or school district below, the specific health and medical information described below:

- Patient ____ Birthdate ______________________
  consisting of:
  (Describe information to be used/disclosed here)
  Any information requested by patient or patient's undersigned representative, or patient's school including, but not limited to immunization records, recent physical exam data, and certification by physician of fitness.
- **Include mental health records ☐ Yes ☐ No Include Alcohol/drug abuse treatment records ☐ Yes ☐ No**
- **Name of Recipient or Class of Recipients:**
  SCHOOL DISTRICT ____
- **SCHOOL OR DAYCARE PATIENT WILL ATTEND SEPTEMBER 2023 THRU JUNE 2024** ______________________

  SCHOOL OR DAYCARE PATIENT WILL ATTEND SEPTEMBER 2024 THRU JUNE 2025 ______________________

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  (Address may be obtained from school at time of request for information) ______________________

- *Phone* ____ *Fax* ______________________
  for the purpose of:
  Documenting physical health status as required or requested in order to attend school and/or participate in school-related activities and programs such as; field trips, sports programs, Early Education, etc.
  Documenting physician's prescriptions and/or recommended treatment to be administered or carried out at school by patient, school nurse, or other school authorized personnel.

  Other purposes ____

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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.

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.

  Unless otherwise indicated this authorization will expire August 31, 2025

- *Adult Patient or Minor 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.)* ______________________

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