Medical Record Transfer Form

I ________________________, hereby authorize ____________________________________
Parent/Guardian Name — Name of Doctor, Practice or Clinic

____
Office Address

____
City, State, ZIP

To release my child(ren)'s medical records to:

☐ **Margiotti & Kroll Pediatrics, P.C.**
4829 E. Street Road
Suite 100
Trevose, PA 19053

☐ **Margiotti & Kroll Pediatrics, P.C.**
Warrington Greene
1432 Easton Road, Suite 5A
Warrington, PA 18976

☐ **Margiotti & Kroll Pediatrics, P.C.**
Village at Newtown Square Shopping Center
2861 South Eagle Road
Newtown, PA 18940

☐ **Margiotti & Kroll Pediatrics, P.C.**
9140 Academy Road
Suite G
Philadelphia, PA 19114

Child's Name	Date of Birth

____
Signature of Parent/Guardian

____
Date

____
Parent/Guardian Name (please print)