



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.**
 Village at Newtown Square Shopping Center
 2861 South Eagle Road
 Newtown, Pa 18940

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

Child's Name	Date of Birth

 Signature of Parent/Guardian

 Date

 Parent/Guardian Name (please print)