Margiotti & Kroll
PEDIATRICS, P.C.

Request for Release of Medical Records Form

I _____, hereby authorize Margiotti & Kroll Pediatrics, P.C. to release my child (ren)'s medical records to:
Parent/Guardian Name

_____
Name of Doctor, Practice, Clinic or Person Receiving Records

_____
Address

_____
City, State, ZIP

ID	Child's Name	Date of Birth
1		
2		
3		
4		
5		
6		

Initials	Authorization to Release Medical Information
	I authorize the release of all information from my children's medical records unless otherwise specified.
	I understand that the requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
	I understand that I may be charged for copying costs.
	This authorization may be revoked at any time. My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization is valid.
	This authorization expires 6 months after the date of signature, or as specified: _____
	I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.
	A photocopy of this release is as effective as the original.
	I have received a copy of this authorization

Check for each child by identifier number above: ( )1 ( )2 ( )3 ( )4 ( )5 ( )6

This includes contents regarding drug and alcohol abuse, psychiatric, psychotherapy notes and HIV related diagnosis and/or test results.
Check for each child by identifier above: ( )1 ( )2 ( )3 ( )4 ( )5 ( )6

Margiotti & Kroll Pediatrics, P.C. is dedicated to providing the best care possible to our patients, and therefore is constantly looking for ways to improve our services. Please tell us briefly why you are leaving our practice:

_____

_____

_____ _____
Signature of Parent/Guardian Date

_____ _____ _____
Parent/Guardian Name (please print) Relationship to Patient Phone number