Margiotti & Kroll
PEDIATRICS, P.C.

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.**
671 Newtown-Yardley Road
Newtown, PA 18940

☐ **Margiotti & Kroll Pediatrics, P.C.**
Valley Square
1501 N. Main Street Suite 230
Warrington, PA 18976

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

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

_____ _____
Signature of Parent/Guardian — Date

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