

New patients transferring into our practice are required to obtain a copy of the medical and immunization record from their former physician. You can use the form below to obtain your records. Please request these records **ASAP** as our office requires this information on your initial visit with us. **If we do not receive the records prior to your scheduled visit you may be asked to re-schedule.**

Thank You!

**Attn: Medical Records**

I hereby authorize the release of my child's (children's) medical records

**From:**

Dr. \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Patient Name(s)**

**Date of Birth**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient/Parent Signature

\_\_\_\_\_

Date

**Records are to be released to:**

**Pediatric Associates of Kingston, LCC**

**425 Tioga Avenue**

**Kingston, PA 18704-5698**

**Phone: (570) 288-6543 Fax: (570) 288-7130**

**J.C. Gaudio, M.D. M.W. Harris, M.D. J.P. Rogers, M.D.**

**A.M. Sehic, M.D. J. R. Kile, M.D.**