CHILD HEALTH CARE ASSOCIATES

Kathleen Stoeckel, M.D.
Vito Losito, M.D.
Rebecca Potter, M.D.
Philip Remillard, M.D.
Rosalind Odin, M.D.
Sandra Skeval, M.D.
Kristine Joseph, M.D.
Sean O'Malley, M.D.
Tracy Massa, M.D.
Thomas Scott, M.D.

REQUEST FOR TRANSFER IN FORM

TO: _____

ADDRESS: _____

_____

PLEASE FURNISH: CHILD HEALTH CARE ASSOCIATES

_____6700 KIRKVILLE ROAD
EAST SYRACUSE, NY 13057
PHONE (315) 463-2013
FAX (315) 463-2019

_____8138 OSWEGO RD
LIVERPOOL, NY 13090
PHONE (315) 652-8800
FAX (315) 652-8808

With records regarding my children's medical history, immunizations, growth records, lab & x-ray results, treatments, medications, allergies, and other patient information.

Please include the child's name and date of birth, and your address and telephone number on the records you send to our office. If you have any names of previous health care providers, please include them to aid us in acquiring any other records.

Child's Name: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Parent Signature: _____ Date:_____

Parent Name in Print: _____