

MYRTLE AVENUE Pediatrics



Greg Savel, MD
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Kimberly Odom, MD

I hereby authorize and request Myrtle Avenue Pediatrics Inc to:

_____ Send medical records or _____ Receive medical records

Please check all boxes below that you would like to request

___ Office notes

___ X-ray reports

___ Vaccine records

___ Entire chart

___ Lab results

___ Date range of records _____

These records are to be forwarded to/received from

Name: _____

Address _____ City _____

State _____ Zip _____

Patient's name _____ Date of Birth _____

Patient's name _____ Date of Birth _____

Patient's name _____ Date of Birth _____

Please state reason for requesting records: (ex. Changing physicians, moving, personal use, insurance purpose) _____

Signature _____ Relationship to patient _____

Print name _____ Date _____

There is no charge for copies from our office to another medical facility. There will be a charge for copies provided to parent/legal guardian. I understand and agree that I am financially responsible for the following fees associated with my request: I understand the charge for paper copy is: \$1.00 per page for the first 25 pages, then \$.25 for each page thereafter. Cost for reproducing medical records are in accordance with the FL administrative register rule 64B8-10.0003 and F.S. 164.524

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