PLEASE RETURN TO:
ZÖe Center For Pediatrics & Adolescent Health, LLC
Attn: Medical Records
210 Hannah's Mill Rd
Thomaston, GA 30286
Fax: 706-647-3861
Phone: 706-938-0990

AUTHORIZATION
FOR RELEASE OF INFORMATION
Please include copy of your picture ID

Patient Name: _____ DOB: ____/____/_____
Last Name First Name Middle Initial

Mailing Address: _____ Phone: (_____) _____
_____
_____

Dates information is to be released:
From___/___/_____ Through ___/___/_____

(Check all that apply)

___ Complete Records **___Labs** **___Radiology /Imaging**
___Copy to Parent **___ Medical Summary** **___Medication List**

The Information may be released as follows:

☐ **From** **ZÖe Pediatrics**
210 Hannah's Mill Rd
Thomaston, GA 30286
(P) 706938-0990 / (F) 706 647-3861

☐ **To** _____
_____
_____
_____

OR ----------

☐ **From** _____
_____
_____
_____

☐ **To** **ZÖe Pediatrics**
210 Hannah's Mill Rd
Thomaston, GA 30286
(P) 706938-0990 / (F) 706 647-3861

Purpose of Release (check all that apply below)

___ Legal Investigation **___Moving Out of Area** **___Insurance**
___Changing PCP **___ School Record** **___Medication List**

***** If transferring to another provider, please provide reason for leaving:** _____
_____
_____
_____

I understand the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Medical Information Services. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the Information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the Information to be released as described above.

_____ _____
Patient/Parent/Legal Guardian Printed Name Parent/Legal Guardian Signature Date

_____ _____
Patient Signature if 19 or older Witness Signature for Patient/Parent/ Legal Guardian Date

Release of Information Guidelines

What You Need to Know About Requesting Copies of Medical Records

THIS FORM MUST BE RETURNED WITH THE AUTHORIZATION

1. The authorization must be:
    a. Completed in full
    b. Completed in black or blue ink
    c. Addressed to ZÖe Pediatrics
    d. Signed by the patient if:
        i. The patient's age today is 19 years or older -OR
        ii. The patient is an Emancipated Minor (married, divorced or born a child)
            - Females under the age of 19 years who are pregnant or who have born a child can authorize the release of medical records of their child.
    e. Signed by either of the patient's parents or the patient's legal guardian if the patient is under the age of 19 years. **A copy of the parent's driver's license is required.**
    If the requesting parent's name is not in the child's record, a copy of the birth certificate must be presented to establish parental relationship.

2. As allowed by Federal and State regulations, reproductions fees for copies of medical records may be required as applicable; ZÖe Pediatrics invoice will accompany the copies of medical records.

***Patients are not charged a search/retrieval fee.**

No charge is made for continued care requests received from other health care providers (hospitals, physician offices, clinics, etc.) Exceptions to these fee schedules are noted by Peer Review Organization contracts and Disability Determination Services standard fee payment.

3. Upon receipt of a completed, valid authorization, copies of medical records may be expected within 5-7 business day. (Not to exceed 30 Days)
    i. Question or follow-up calls regarding the status of requests may be directed to ZOe Pediatrics, Release of Information staff at 706-938-0990.

To cover the cost of copying and mailing, state law provides for a charge of .97 cents per page plus supplies & postage. ***O.C.G.A. 31-33-3***

PAGES 1-20: $1.00 per page Pages 21+: $.50 per page

By signing this form, I acknowledge that I have read the above and have no further questions about the information listed.

_____	_____
Patient/Parent/Legal Guardian Printed Name	Parent/Legal Guardian Signature Date
_____	_____
Patient Signature if 19 or older	Witness Signature for Patient/Parent/ Legal Guardian Date