PLEASE RETURN TO:
ZÖe Center For Pediatrics & Adolescent Health, LLC
Attn: Medical Records
210 Hannah's Mill Rd
Thomaston, GA 30286
Fax: 360-462-5817
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** **___Immunization Record**

The Information may be released as follows:

☐ **From** **ZÖe Pediatrics**
210 Hannah's Mill Rd
Thomaston, GA 30286
(P) 706938-0990 / (F) 360-462-5817

☐ **To** _____
_____
_____
_____

OR ----------

☐ **From** _____
_____
_____
_____

☐ **To** **ZÖe Pediatrics**
210 Hannah's Mill Rd
Thomaston, GA 30286
(P) 706938-0990 / (F) 360-462-5817

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

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

Pursuant to O.C.G.A §31-33-3, effective July 1, of each year, the costs related to medical record retrieval, certification and copy may be adjusted in accordance with the medical component of the consumer price index.
Accordingly, the rates effective July 1, 2022, are as follows:

Copying Costs for Records in Paper Form

- Per page for pages 1-20: $0.97
- Per page for pages 21-100: $0.83
- Per page for pages over 100: $0.66

Certification Fee

- Up to Per Record: $9.70

Copying Costs for Records in Electronic Format

- Flat fee of $6.50 per request

However*, the fee limitation set forth in 45 CFR §164.524(c)(4) applies only to individuals' requests for access to their own PHI and does not apply to an individual's request to transmit PHI to a third party.*

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