ZAMAN PEDIATRICS

Pediatric & Adolescent Medicine
2800 Main Street West • Snellville, GA 30078
Ph: (770) 979-2600 • Fax: (770) 736-0014 • www.zamanpediatrics.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

****Medical Records request must be in writing and received in our office at least 72 hours before the date needed. It can take up to 10-14 days to process the request. Fees for the services are applicable and must be paid prior to releasing records! ****

HEREBY AUTHORIZE ZAMAN PEDIATRICS TO:

(Check one below)

_____**RELEASE INFORMATION TO:** _____**OBTAIN INFORMATION FROM:**

_____
(Attorney/Individual/Physician)

_____ _____
(Street Address) (City, State, Zip Code)

_____ _____
(Phone) (Fax)

Requesting Information:

_____ Last Annual Visit
_____ Immunization Record

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Delivery Method: _____Pickup, ____ Mail to address above, _____Fax

I understand this authorization includes the release of all medical records including HIV records, Psychiatric, Drug/Alcohol abuse, Venereal disease and any other statutory protected diseases. This authorization and consent will expire (90) days following the date signed. I understand that I may revoke this authorization at any time except to the extent that the extent action has previously been taken in reliance hereof.

_____ _____ _____
Parent or Guardian Signature **Relationship** **Date**