Lillian Schapiro, MD
Daniel Geller, NP

3200 Downwood Circle
Suite 220
Atlanta, Georgia 30327
470-312-3696

Patient's Name _____ D.O.B. _____

Address _____ City _____

State _____ Zip code _____

Home Phone _____ Cell Phone _____

Medical Records Released From:

Name _____ Address _____

Suite _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Medical Records to be Sent to:

Ideal Gynecology
3200 Downwood Circle, NW
Suite 220
Atlanta, GA 30327
470-312-3696 Fax: 404-549-3922

Information to be Disclosed:

___ Complete Medical Record (Including HIV/STD Screening)
___ Specific Labs Dated _____ Specify Labs _____
___ Date of Medical Records from: _____ to_____
___ Other (please specify) _____

Reason for Request:

___ Out of town move ___ Change of Insurance ___ Insurance claim ___ Legal
___ Consult/2nd Opinion ___ Personal copy ___ Transfer care ___ Other

Revocation:

I understand that this authorization will be in effect for one year, unless cancelled by me in writing.

Patient/guardian Signature _____ Date _____