Lilian Schapiro, MD
Xiaoyan Lee, WHNP
Kaley Hudson, PA-C
Courtney Blue, NP
Niambi Smith, DNP
Serena Pascal, WHNP



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

A FEE MAY APPLY FOR THE PROCESSING OF MEDICAL RECORDS

Patient Name: _____Date of Birth: _____

Address: _____

City: _____State: _____Zip Code: _____

Home Phone: _____Cell Phone: _____

MEDICAL RECORDS RELEASED FROM:

Name / Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____Fax Number: _____

MEDICAL RECORDS SHOULD BE SENT TO:

Name / Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Fax Number: _____

INFORMATION TO BE DISCLOSED

___ Complete medical record (including HIV, STD screening).

___ Specific labs dated _____

Specify the lab _____

*Medical Record Date Range: From*_____TO:_____

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REASON FOR THE REQUEST

___Moving out of the city

___Change in insurance

___Insurance claim

___Legal

___Consultation/2nd Opinion

___Personal copy

___Transfer of care

___Other

REVOCATION

I understand that this authorization will be valid for one year, unless I cancel it in writing.

Patient/Guardian signature:

_____