18404 N Tatum Blvd
#207 Phoenix AZ 85032

CHOPRA UROLOGY

SAMEER CHOPRA MD LLC

Phone: 602-777-3113
Fax: 602-726-3008
ChopraUrology.com

Patient Identifying Information:

Patient Name: _____ Date of Birth: _____

Address: _____ City_____ State_____ Zip Code_____

Phone Number: _____ Date(s) of Service(s): _____

Release of medical records from SAMEER CHOPRA MD PLLC:

I authorize SAMEER CHOPRA MD PLLC to release my medical records as I have indicated in **Section 2:**

Disclose to: _____

Address: _____

Phone: _____ **Fax:** _____

Specific Description of Information to Be Disclosed (check all that apply):

☐ Discharge Summary, History and Physical Exam, Operative Reports, Consultation reports

☐ X-ray Reports, Pathology, Lab Testing, Progress Notes

☐ Pertinent Records Only Other (Specify)_____

Specific description of the purpose of disclosure:

☐ The disclosure is at the patient's request Other(Specify)_____

I authorize the provider to use or disclose information related to:

☐ AIDS/HIV ☐ Genetic Testing Information

☐ Psychiatric Care Reports ☐ Alcohol and/or Drug Abuse Treatment

I understand that SAMEER CHOPRA MD PLLC will not condition on my signing this authorization. SAMEER CHOPRA MD PLLC will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time with some exceptions. For more details on when I can or cannot revoke this authorization, I can read SAMEER CHOPRA MD PLLC Notice of Privacy Practices.

To revoke my authorization, I must submit written request to SAMEER CHOPRA MD PLLC. Unless I revoke the authorization earlier, it will expire upon its completion or 180 days from the date of signature, whichever comes first. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulation and may be re-disclosed by the person or organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associated to the extent indicated and authorized herein.

Please note if you request a copy of your medical records for your own personal use there will be a $30 charge.

Signature of Patient: _____ Date: _____

Signature of Legal Representative: _____ Relationship to Patient: _____

CHOPRA UROLOGY

SAMEER CHOPRA MD LLC

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Phone Number: _____ Date (s) of Service(s): **ALL MEDICAL RECORDS**

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Phone: 602 777-3113 Fax: 602 726-3008

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