CHOPRA UROLOGY

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Patient Authorization for Release of Prescription Drug Information

I, _____ **Date of Birth** _____, hereby authorize any pharmacy, pharmacy benefit manager (PBM), health plan, healthcare provider, or any other entity maintaining my prescription medication records to disclose my prescription drug information, including current and past medications, prescription refill history, dispensing records, allergy information, adverse drug reactions, and controlled substance prescription history, to Sameer Chopra MD PLLC. I understand that this information is requested to assist my healthcare providers in delivering safe and effective medical care, including evaluating my medical condition, verifying my medication history, identifying potential drug interactions, preventing duplicate or conflicting prescriptions, coordinating treatment among healthcare providers, ensuring accurate medication reconciliation, and complying with applicable standards of care. I understand that the release of this information will help my healthcare providers make informed clinical decisions regarding my diagnosis, treatment, and ongoing care. I acknowledge that this authorization is voluntary and that I may revoke it at any time by providing written notice, except to the extent that action has already been taken in reliance on this authorization. This authorization shall remain in effect until revoked by me in writing.

Patient Signature: _____**Date**: _____

Printed Name: _____ **Date**: _____

If signed by a personal representative:

Representative Name: _____ **Date**: _____

Representative Signature: _____ **Date**: _____

Relationship to Patient: _____