GOBINDER S. CHOPRA, MD

Board Certified in Neurology

CONSENT TO RELEASE INFORMATION

I hereby authorize the release of any and all medical records, test results or other information contained in my medical chart to Gobinder S. Chopra, MD from any doctor or medical facility where medical services have been rendered to me. This release shall be made to include any records considered sensitive, i.e., psychological or psychiatric impairment(s) or condition(s); drug or alcohol, abuse or treatment(s); sickle cell anemia, AIDS, or test for infection with HIV.

I further understand that this consent to release information will allow Gobinder S. Chopra, MD to release any information in my medical chart to my insurance company regarding billing claims and request for information; my selected pharmacy and/or pharmacist; referring doctors or other doctors/specialist who are treating me or to whom I am being referred to for additional care; and hospital or medical facility where I have obtained medical treatment or where treatment may be sought or to any person whom I have listed in the release of information. I understand that this includes records considered sensitive, i.e., psychological or psychiatric impairment(s) or condition(s); drug or alcohol, abuse or treatment(s); sickle cell anemia, AIDS, or test for infection with HIV.

____ ___________________

Patient Signature Date

ADDITIONAL ACKNOWLEDGEMENT

Please be advised that it is mandatory by Nevada Statute that if Gobinder S. Chopra MD becomes aware of any medical condition that may affect your ability to operate a motor vehicle this information will be released to the appropriate State Authority. This may result in a suspension of your drivers License.

Further, if at any time an attorney request records from this office said attorney must provide a Release for medical records which includes the above mentioned sensitive records release or subpoena the records by official process from an appropriate court of law. To insure confidentiality, this medical information will **only** be faxed to another medical facility. We do not fax to a private residence or attorney's office.

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Patient Signature Date

Acknowledgement of Review of Notice of Privacy Policy

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____ ______________________________

Signature of patient Date

For office use only

Notice of privacy practices sent/delivered on _____________Initials__________________________

Signed Acknowledgement of Receipt received on __________________Initials________________

Patient refused or failed to Acknowledge Receipt on ________________ Initials________________