HealthCore Physicians Group
8210 Walnut Hill Lane, Suite 230
Dallas, Tx 75231

Phone: (972) 284-7000
Fax: (972) 284-7001
www.healthcoreweb.com

Authorization for Release of Patient Information

Patient Name: _____ Date(s) of Service: _____

Date of Birth: _____ Social Security #: _____

I, the undersigned, authorize the release of, or request access, to the information specified below **FROM**:

_____
Name (Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State, Zip)

Purpose of Release:

❑Continuing Medical Care ❑Military ❑Social Security/Disability
❑Insurance ❑Personal Use ❑School
❑Legal Purposes ❑Other (please specify) _____

Information to be Released or Accessed:

❑Face Sheet ❑History & Physical ❑Progress Notes
❑Care Plan ❑Radiology Reports ❑Lab/Pathology Reports
❑EKG Reports ❑Consultation Reports ❑Operative Reports
❑Hospital Reports ❑Medication Record ❑ER Reports
❑Discharge Summary ❑ Other (please specify) _____

The above information may be released **TO** (specify name of the individual or organization to which records are to be released and the appropriate address):

_____
Name (Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State, Zip)

I understand that my records are confidential and cannot be released or disclosed without my written authorization, expect when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

I understand that HealthCore Physicians Group will provide this information within 15 days from receipt of

HealthCore Physicians Group
8210 Walnut Hill Lane, Suite 230
Dallas, Tx 75231

Phone: (972) 284-7000
Fax: (972) 284-7001
www.healthcoreweb.com

request. I understand I may be charged retrieval/processing fee if my records are located at off-site storage. I also understand that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Date:_____ Signature: _____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____ _____

For departmental use: Acct# Relationship to Patient