HealthCore Physicians Group
(972) 284-7000

8210 Walnut Hill Lane, Suite 230
Dallas, Texas 75231

Re: _____ _____
(Patient Name) (Date of Birth)

PATIENT PORTAL ACTIVATION

Our office now has the ability to communicate with patients through an electronic Patient Portal. This portal will allow you to request appointments, view lab results, view current scheduled appointments, request medication refills, request referrals to specialists, complete medical questionnaires, view summaries of your recent visits and more. In order to activate this functionality for you personally, we MUST have an active e-mail address associated with your account.

Please list your e-mail address here: _____@_____
We will activate your account today and you will receive and e-mail within 24-48 hours with your login information.

AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I authorize this office to have access to my prescription drug history. I understand this authorization allows this office to obtain my prescription history electronically from retail pharmacies.

_____ _____
Patient's Signature Date

AUTHORIZATION TO DISCLOSE IMMUNIZATION INFORMATION TO STATE REGISTRY

_____ _____
Patient's Signature Date

AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION

Federal privacy guidelines, HIPAA, prevent this office from disclosing protected health (PHI) to anyone other than the patient. By signing this form, you are allowing us to communicate with designated individuals regarding your medical and financial record with this facility.

I, the undersigned, hereby authorize HealthCore Physicians Group to disclose PHI from my medical or financial record to the following person/people:

1. Name: _____

Relationship: _____

Type of Information: (Circle One) Medical Financial Both

ADDITIONAL PERSONS MAY BE LISTED ON THE OTHER SIDE IF NECESSARY

This authorization is given freely with the understanding that:

1. I may revoke this authorization in writing at any time, but not retroactively.
2. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.

_____ _____
Patient's Signature Date