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

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

Dr. Michael McCullough Retirement Notice

5/20/2018

Dear Patients,

Over the past fourteen months, Dr. Michael McCullough has been a part of HealthCore Physicians Group. We appreciate these months of service and care Dr. McCullough provided to his patients. Effective June 19, 2018, Dr. McCullough will no longer be working with our practice as he is retiring from daily patient care. His last day seeing patients will be Monday, June 18, 2018. We are very sorry for the inconvenience this may cause.

Some HealthCore physicians are accepting transfer of care patient requests from Dr. McCullough's current patients. Please contact our office as soon as possible if you would like to transfer your care to another HealthCore physician. We will make accommodations for transfer requests as we are able. Please note that transfer acceptance varies by physician. Alternatively, if you wish to locate another Internal Medicine provider outside of our practice, please refer to the Dallas County Medical Society website at www.dallas-cms.org, or contact your insurance provider for a list of in-network providers.

Your medical record will be maintained by HealthCore in our office. If you need copies of your records or wish to have your records transferred elsewhere, please complete the enclosed "Authorization for Release of Information" form, return it in the provided envelope, and we will forward your request for processing. There may be a fee associated with your records request, but you will be notified in advance of any applicable fee.

If there is any additional information that you need from our office, please contact our Office Manager, Victor Montejo, at (972) 284-7047.

We welcome you to join us in bidding Dr. McCullough a fond farewell on the evening of June 18, 2018 from 5PM-7PM in the conference room located adjacent to our office.

Thank you.

Sincerely,
HealthCore Physicians Group

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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**:

HealthCore Physicians Group (972) 284-7000
Name (Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

8210 Walnut Hill Lane, Suite 230 Dallas, Tx 75231

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 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 of Patient or Legally Authorized Representative

_____ _____
Relationship to Patient Printed Name of Patient or Legally Authorized Representative