CORE PHYSICIANS
an exeter health resource | The Art of Wellness

PHI (Personal Health Information) DISCLOSURE AGREEMENT

Patient Name:_____ Date of Birth:_____

I hereby grant permission for Core Physicians (Core), to verbally discuss my personal health information to the following individuals named below. The sole purpose of this form is to protect my privacy by ensuring that my health care will be discussed only with individuals I have chosen.

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

Information to be discussed:

☐ **Ability to Access and/or Reschedule Appointment Dates & Times on Behalf of Patient**

☐ **Test Results**
Including but not limited to: X-Rays, CT Scans, Pulmonary Function Tests, Lab Work, PET Scans, Bronchoscopes, etc.

☐ **Any other pertinent health related information related to treatment at this facility**
This may include the following, please initial (if not initialed, it will **not** *be released):*

_____ HIV – Related including AIDS _____Sexually Transmitted Diseases

_____ Drug and Alcohol Abuse Treatment _____Mental Health

_____ Genetic Testing

☐ **Ability to Pick Up Prescriptions on Behalf of Patient**

I understand that this permission may be revoked by me at any time by written notice to Core, but that revoking it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my Core provider or office to verbally share my information with someone.

_____ _____
Printed Name of Patient or Legal Representative/Guardian *Date*

_____
Signature of Patient or Legal Representative/Guardian