



Authorization to Use or Disclose My Health Information

Patient Information:

Print Patient's Full Name

Date of Birth (Month/Day/Year)

Street Address

Daytime Phone Number

City, State, Zip Code

Release Medical Records From:

Associates In Family Medicine (or)

Doctor or Hospital

Street Address

City, State, Zip Code

Phone Number Fax Number

Send Medical Records To:

Associates In Family Medicine (Check location below) (or)

Doctor or Hospital

Street Address

City, State, Zip Code

Phone Number Fax Number

PLEASE MAIL RECORDS IF MORE THAN 15 PAGES.

Lemay Office
1107 S. Lemay Ave, Ste. 200
Fort Collins, CO 80524
Ph: 970.484.1757
Fax: 970.484.9924

Horsetooth Office / Urgent Care
3519 Richmond Drive
Fort Collins, CO 80526
Ph: 970.204.0300
Fax: 970.226.9041

South Office
1113 Oakridge Drive
Fort Collins, CO 80525
Ph: 970.225.0040
Fax: 970.225.2996

Timberline Office
2025 Bighorn Drive
Fort Collins, CO 80525
Ph: 970.229.9800
Fax: 970.229.1421

CSU Office
151 W. Lake St., Ste. 1500
Fort Collins, CO 80524
Ph: 970.237.8200
Fax: 970.237.8291

West Office
2001 S. Shields, Bldg I
Fort Collins, CO 80526
Ph: 970.221.5255
Fax: 970.221.5206

Windsor Office
1455 Main St. Ste. 150
Windsor, CO 80550
Ph: 970.686.0124
Fax: 970.686.0845

Foxtrail Office
1625 Foxtrail Drive
Loveland, CO 80538
Ph: 970.619.6900
Fax: 970.619.6900

Harmony Office
2121 E. Harmony Rd. Ste. 370
Fort Collins, CO 80528
Ph: 970.221.2290
Fax: 970.221.2293

Information to be released:

- 2 years of medical records
- Just my health information relating to the following condition or treatment: _____
- Include records related to: psychological or psychiatric conditions; Alcohol and/or drug abuse; HIV/AIDS
- Other _____

Purpose of Disclosure:

- Referral to a specialist
- Permanent Transfer
- Personal
- Insurance
- Workers Comp
- Legal Investigation
- Disability Determination
- Other _____

There will be a charge for a personal copy of your records from AFM. Healthport has been contracted to provide this service for AFM and will invoice you directly. The fee schedule is: \$14.00 for ten (10) or fewer pages; \$0.50 pp for pages 11-40; \$0.33 pp after 40 pages, plus postage. AFM does not control charges from other facilities when records are being released to us.

This authorization is valid for 1 year from date of signature unless otherwise indicated: _____

Patient Rights:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, either complete a Revocation of Authorization Form or provide written communication to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Printed name of patient or person signing on behalf of patient

Relationship, if not patient
(parent/legal guardian/personal representative/etc.)