University of Colorado Health Employee Health Clinic
Managed by ASSOCIATES IN FAMILY MEDICINE
151 W. Lake Street, Suite 1500 Fort Collins, CO 80524
Phone: (970) 237-6339 *Fax:* (970) 482-2091

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:

☐ University of Colorado Health Walk-In & Employee Health Clinic
(or)
☐
Doctor or Hospital

Street Address

City, State, Zip Code

Phone Number Fax Number

Send Medical Records To:

☐ University of Colorado Health Walk-In & Employee Health Clinic
(or)
☐
Doctor or Hospital

Street Address

City, State, Zip Code

Phone Number Fax Number

PLEASE MAIL RECORDS IF MORE THAN 15 PAGES.

Information to be released:

☐ 2 years of medical records
☐ Employee Assistance Service (with Poudre School District)
☐ Laura Dvorak RN, Lifestyle Health Manager
☐ 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. 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.)

Form updated November 2018.