ASSOCIATES IN FAMILY MEDICINE

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

PLEASE MAIL RECORDS IF MORE THAN 15 PAGES.

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

☐ **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 / Urgent Care**
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 / Urgent Care**
1683 Main St.
Windsor, CO 80550
Ph: 970.686.0124
Fax: 970.686.0845

☐ **Foxtrail Office**
1625 Foxtrail Dr, Ste. 190
Loveland, CO 80538
Ph: 970.619.6900
Fax: 970.619.6990

☐ **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 (recommended)
☐ 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 (specific dates of care or treatment) _____

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.)