



FORT COLLINS YOUTH CLINIC
CARING FOR OUR FUTURE GENERATIONS

WELCOME TO THE FORT COLLINS YOUTH CLINIC

We are pleased that you have chosen the Fort Collins Youth Clinic to care for your child's health-care needs. Pediatricians spend many years in training to treat only children. They recognize that children's needs are unique and that they are not just "little adults." Our pediatricians, physician assistants, nurses and other staff consider themselves a team designed to help you have healthy children and to make parenting easier. We are always striving to improve our services and welcome your suggestions and criticisms.

One of our pediatricians is on call at all times. Availability is an important part of our care and someone from the practice is always "on call." The "on call" doctor makes rounds at the hospital and is part of the teaching faculty for the local residency program. This means that your physician will not always be in the office to see your child for illness, and you will likely see different providers for acute illness and emergencies. However, we do encourage you to develop a special relationship with one of the group for ongoing preventive care and special needs.

Provider's fees are a reasonable concern for any patient. If you have questions regarding our fees please contact the business office. Good doctor-patient relationships depend on an understanding of the fees involved.

As a staff, we are interested in all aspects of health, growth and development that will ultimately affect a child's overall well being. For that reason we feel very strongly that it is important to see children on a regular basis for well care visits. These times are set aside not only to get to know you and your child better, but also to address ongoing issues such as development, nutrition, behavior, discipline, and safety. Of course, a complete physical exam is part of this process and attention is given to any chronic health problems such as asthma, poor growth, etc. We hope you will use these visits to discuss any ongoing concerns you may have as well. In this way, we hope to anticipate your child's health needs as he or she matures. Knowing your child in a "well" state helps us to deal effectively with illness when it occurs.



Youth Clinic

1200 E Elizabeth Street ~ Fort Collins, CO 80524 ~ Ph 970.416.6267 ~ Fax 970.482.2635

Authorization for Release of Information

Patient Name _____
 LAST FIRST MI MAIDEN / OTHER NAME

Date of Birth _____ Medical Record # _____
 (Office Use Only)

Address _____ City _____ State _____ Zip _____

Daytime Phone _____ Evening Phone _____

I hereby authorize the release of medical records as indicated below:

Released **from:**

Released **to:**

Name _____

Address _____

Phone _____

Fax _____

Name _____

Address _____

Phone _____

Fax _____

Information to be released

- History and physical exam
- Progress notes
- Lab reports
- X-ray reports
- Other: _____

Dates requested

ONLY THE PAST 5 YEARS OF RECORDS ARE PROVIDED UNLESS OTHERWISE REQUESTED

I specifically authorize the release of information relating to:

- Substance abuse (including drug and alcohol abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)

 Signature of Patient, Parent or Legal Guardian Date

Purpose of Disclosure

Is patient transferring out of the practice: _____ Yes _____ No

If **yes**, please indicate the reason

- Change of insurance
- Moving out of area
- Family consolidation
- Aged out
- Unhappy with care of service

Name of new insurance carrier _____

If **no**, please indicate the reason

- Specialist
- Consultation / second opinion
- Personal use
- Other (please specify) _____
- Legal
- Insurance request
- Verbal exchange only

PLEASE NOTE - A fee will be charged for records copied for legal, personal and insurance company requests.

(continued)

I understand the following:

1. This authorization will expire one year after the date this form is signed.
2. I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
3. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by Federal privacy regulations.
4. I am being requested to release this information by _____ (print name of provider) for the purpose of:

 - a. By authorizing this release of information, my health care and payment for my healthcare will not be affected if I do not sign this form.
 - b. I understand I may see and copy this information described in this form if I ask for it and that I will get a copy of this form after I sign it.
 - c. I have been informed that _____ (print provider name) will will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. Compliance with Colorado statute, I will pay a fee of \$ _____ (print fee charged). There is no charge for medical records if copies are sent to the facilities for ongoing care or follow up treatment.

****INCOMING RECORDS ONLY****

Your provider will review these records and the contents felt to be clinically useful will be scanned to your electronic health record. It is impractical for FCYC to store or scan the entire file. We encourage you to keep these records for your own files and future needs. Please select one of the following options. Option A is recommended.

____ A. After selective parts of the transferred record are scanned to the electronic health record, I agree to pick these up within 30 days, after being notified, and retain for my own records.

____ B. After Selective parts of the transferred record are scanned to the electronic health record, I give my permission for FCYC to shred the entire copy of the record.

Signature of Patient

Date

Signature of Parent or Legal Guardian

Date

Records Received By

Date

Relationship to Patient

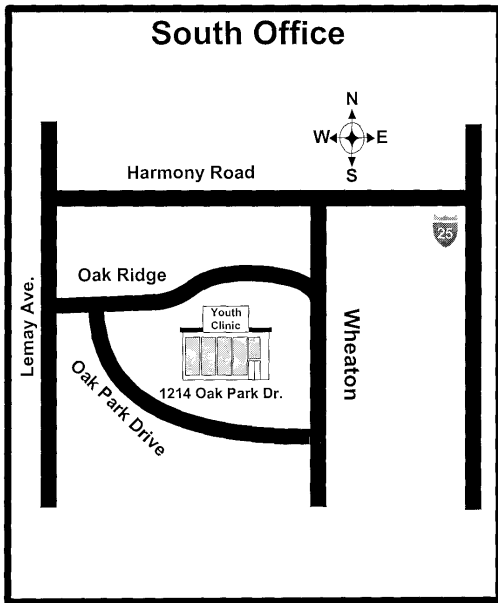
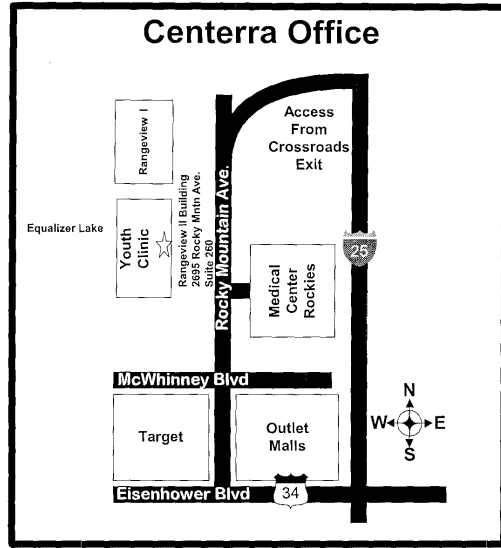
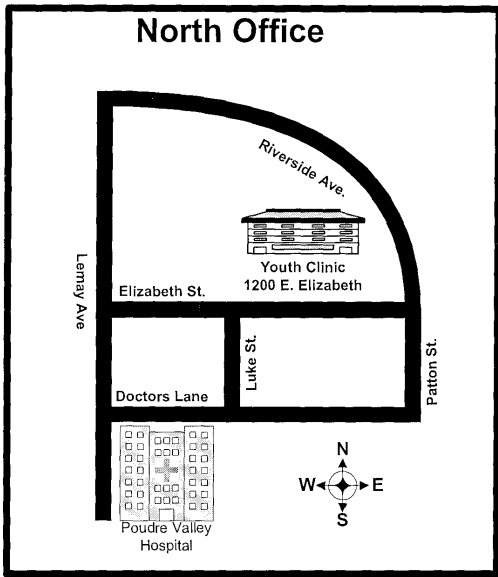
FOR OFFICE USE ONLY

Date Request Filed _____

By _____

Identification Presented _____

Fee Collected _____



Participating Insurance Companies

Medical

Aetna
Anthem
Beechstreet
Cigna
CHP+
Choice Care
Cofinity
Colorado Blue Advantage
Coventry
First Health
Great West
Humana
Medicaid
Pacificare
PHCS
United Healthcare
UMA Poudre R-1
UMA Poudre Valley Hospital

Psychology

Cofinity
Employee Assistance Program – Kodak
First Health
Great West

Speech

Anthem
Cofinity
First Health
Great West
United Healthcare