Strong Family Health Center

"Comprehensive Tribal Healthcare"

1203 Oak St. Alturas, CA. 96101-3225

Phone (530) 233-4591 Fax (530) 233-3055

RELEASE OF INFORMATION:

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

The purpose for this information is to provide up to date Medical, Dental, Mental Health, Vision and/or Education support and services.

Client Name: _____ D.O.B. ___/___/___ S.S.N. _____

_____ (____)_____

Physical Address City/State/Zip Code Phone Number

_____ (____)_____

Mailing Address City/State/Zip Code Cellular Number

Please provide the name and contact number of your health care providers in the space given below.

Medical Doctor:_____

Dentist:_____

Eye Doctor:_____

Hospital:_____

Specialty Care:_____

Mental Health Provider:_____

Federally Recognized Tribes (Specify):_____

School:_____

Dept. of Social Services: _____

Other (Specify):_____

I authorize the release of protected healthcare information (PHI) by providers that I see and their out-sourced billing associates. In addition, Strong Family Health Center (SFHC) is my payer of last resort and should be billed as such. I authorize my providers to address SFHC with any billing/payment issues. Providers may disclose my PHI necessary for medical appointments, treatments, consultations, billing, claims and payments. This authorization shall be inforce and effective until 2 years from signature date at which time this authorization expires. I understand that I have the right to revoke this authorization in writing, at any time, but in doing so the revocation may limit my PRC services. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

_____ _____

Signature of Client Date

_____ _____

Parent/Guardian of Minor Client Date

_____ _____

Signature of Witness (If signed with an X) Date

This information is to be released for the purpose state above and may not be used by the recipient for any other purposes. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 U.S.C. 552a (1) (3). In the case of alcohol and drug abuse patient records, a falsified authorization of disclosure is also prohibited under 42 CFR 2.31 (d) 12/12