

**Strong Family Health Center**

“Comprehensive Tribal Healthcare”

1203 Oak St. Alturas, CA. 96101-3225

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

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_/\_\_\_/\_\_\_ S.S.N. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physical Address City/State/Zip Code Phone Number

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Mailing address City/State/Zip Code Cellular Number

*I authorize the release of protected healthcare information (PHI) by provider that I see and their out-sourced billing associates. In addition, Strong Family Health Center (SFHC) is my payer of last resortand should be billed as such. I authorize my providers to address SFHC with any billing/paymentissues. Provider may disclose my PHI necessary for medical appointment, treatments, consultations,*

*billing claims and payments. This authorization shall be inforce and effective until 2 years fromsignature date at which time this authorization expires. I understand that I have the right to revoke thisauthorization in writing, at any time, but in doing so the revocation may limit my PRC services. Iunderstand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.*

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Signature of Client Date

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Parent/Guardian of Minor Client Date

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Signature of Witness (If Signed with an X) Date

This information is to be release for the purpose stated above and my not be used by the recipient for any other purposes. Any person who

knowingly and willfully requests or obtains any record concerning and 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

Strong Family Health Center

Updated 3/2017 By. CC