



County

## CONSUMER CONSENTS AND RIGHTS

<b>Consumer Name</b>			
	<i>Last</i>	<i>First</i>	<i>Middle</i>
<b>Address</b>			
	<i>Street</i>	<i>City</i>	<i>State</i> <i>Zip</i>
<b>SSN</b>		<b>Medicaid #</b>	

### A. SERVICE SETTING

I understand that I have been assessed and that if I am eligible for nursing facility level of care:

I choose to receive services:  as a resident of a nursing home /  as a resident of my own home.

### B. PROVIDER AGENCIES

I have chosen my first choice: \_\_\_\_\_ or my second choice \_\_\_\_\_ as my case management agency. If these agencies are not available, I understand that one will be selected for me.

I have no preference, please select a case management agency for me.

I have chosen my first choice: \_\_\_\_\_ or my second choice \_\_\_\_\_ as my in-home provider agency. If these agencies are not available, I understand that one will be selected for me.

I have no preference; please select an in-home provider agency for me.

### C. RELEASE OF INFORMATION

I authorize the Long Term Care Authority of Tulsa to share with providers my medical or social information necessary to arrange and evaluate services that will enable me to regain or maintain my personal independence.

Pursuant to Oklahoma Statute, Title 63, Section 1-502(B), I have been advised that the information I authorize for release may include information that could be considered information about communicable diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus (AIDS), also known as Acquired Immune Deficiency Syndrome; and, such information may include information concerning any condition of psychiatric illness, drug abuse, alcoholism, and Sickle Cell diseases.

I understand my information will not be released in any way that would identify me to other agencies or agents without my prior written consent.

This authorization is in effect for one (1) year from the original date of my signature. I understand that I may revoke this authorization at any time.

### D. RIGHT TO FAIR HEARING

I have been informed of my right to a fair hearing. I understand that I have the right to appeal any action of the Oklahoma Department of Human Services, which I consider improper by reporting my complaint, in writing, to the Director, DHS, P.O. Box 25352, Oklahoma City, OK 73125.

<b>Signature of Consumer or Legal Agent</b> <small>(If Consumer signs with mark, two witnesses are required.)</small>	<b>Date</b>
<b>Signature of Witness</b>	<b>Date</b>
<b>Signature of Witness</b>	<b>Date</b>