



County

SERVICE TEAM RELEASE OF INFORMATION

Member Name			
	<i>Last</i>	<i>First</i>	<i>Middle</i>
Address			
	<i>Street</i>	<i>City</i>	<i>State</i> <i>Zip</i>
Medicaid #			

A. ACKNOWLEDGEMENT

I authorize the Oklahoma Department of Human Services to share with the providers named below my medical or social information necessary to arrange and evaluate services that will enable me to regain or maintain my personal independence.

I authorize release of my Medicare records, if currently receiving Medicare services, to the Oklahoma Department of Human Services 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 non communicable or communicable diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus (AIDS), also known as Acquired Immune Deficiency Syndrome.

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.

B. SERVICE TEAM MEMBERS

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