



ADvantage Program
SERVICE TEAM RELEASE OF INFORMATION

Form with fields: Member last name, First name, Middle initial, Medicaid number, Street address, City, County, State, Zip

ACKNOWLEDGEMENT

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

I also authorize release of my records to OKDHS 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.

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 year from the original date of my signature. I understand that I may revoke this authorization at any time.

Table with 2 columns and 6 rows, titled SERVICE TEAM MEMBERS

Signature of member or legal agent Date
If member signs with a mark, two witnesses are required

Signature of witness Date Signature of witness Date