STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY
NEWS MEDIA AND MEDIA PRODUCTION
RELEASE OF INFORMATION FORM

Name:_____ Date:_____

Address:_____

City_____ State: OK Zip: _____

Member ID #: _____ Phone No.: _____

I, _____ do hereby give the Oklahoma Health Care Authority full permission to use or release the information in the categories checked below. I understand that this information about me will be used to promote public awareness about Oklahoma's health care programs, to train and educate Oklahoma employees and designees of the state and to educate persons with an interest in Oklahoma health care issues. I further understand that I will not receive any fee or compensation for the use of this information, nor will I receive any royalty for its use. I further understand that the information, in written, oral, picture or video form is prohibited from use for commercial purposes. I further understand that by signing this form, I have waived certain confidentiality protections provided to me by state and federal law.

☐ Name ☐ Photographs/Video Image

☐ Voice ☐ Address (street, city, town or county)

☐ Other (Specify) _____

Signature: _____

(Signature of parent or legal guardian if person is a minor child or incapacitated adult)

* Witness: _____

Address: _____

* Approval: _____

(Appropriate OHCA Administrator, Director or Public Information representative)

Comments: