☐**Living Choice** ☐**Medically Fragile**

RELEASE OF INFORMATION

Participant Name				**SoonerCare ID**	
	Last	*First*	*MI*		

A. ACKNOWLEDGEMENT

I authorize the Long Term Services and Supports of the Oklahoma Health Care Authority 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 the release of all my Medical records to the Long Term Services and Supports 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 (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

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

Oklahoma Health Care Authority (LTSS)

Signature of Participant or Legal Agent *(If Participant signs with a mark, two witnesses are required.)*	**Date**	**Signature of TC/CM**	**Date**
Signature of Witness	**Date**	**Signature of Witness**	**Date**