Client Assistance Program
2401 NW 23rd Street, Suite 90, OKC, OK 73107

RELEASE OF INFORMATION (Please print clearly)

NAME: _____

TO WHOM IT MAY CONCERN:

I have requested to be my advocate in helping me receive services from the State of Oklahoma Client Assistance Program (CAP). In connection with such services I do hereby:

1. Authorize and request any person, school, physician, clinic, hospital or agency to furnish to CAP full and accurate social, education, psychiatric, and medical documentation of any subject regarding myself and/or any other information that might be helpful to CAP;

2. Acknowledge that this authorization includes my confidential medical records;

3. Release any person, school, physician, hospital, or agency from any liability for furnishing information pursuant to this *Release of Information*; and

4. Authorize appropriate U.S. Government officials to review the contents of my CAP files including information released pursuant to this *Release of Information*. Such review is to monitor CAP's compliance with federal statutes. Such officials may not disclose any personally identifiable information observed in such review.

I understand that I am not required to use the Client Assistance Program to dispute any actions affecting my rehabilitation program or appeal a decision of the Department of Rehabilitation staff. My options also include representing myself, asking a friend or family member to act as my representative or hiring legal counsel at my own expense.

Copies of this form and signature are to be considered as valid as the original. This release is valid for one (1) year from the date below.

Signed: _____ **Relationship**: _____

Dated: _____ **Address**: _____

_____

Phone Number _____

Fax: (405) 522-6695
Voice: 800 522-8224
Email: CAP@odc.ok.gov