eoctech.edu
EASTERN OKLAHOMA COUNTY TECHNOLOGY CENTER
ADULT DAY SERVICES
4601 N CHOCTAW RD, CHOCTAW, OK 73020 • 405.390.4400

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: ____SS # _________________

DOB ____/____/_____   Male _____   Female _____

The purpose of this disclosure:_______________________________________

This authorizes the below named physician, hospital or other organization, agency or person having medical, health, social or economic records, data or information concerning the above identifies participant to furnish such records as may be required on my behalf by the *EOC Tech Adult Day Center (ADC)*
This also authorizes the *ADC* to furnish medical, health, social or economic records, data, or information concerning the above identified applicant to the below named physician, hospital or other organization, agency, or person having need for such information.

The participant understands that this authorization is needed to provide *ADC* for coordination of medical, health, social or other related services. It is understood that information thus obtained by *ADC* will be treated as confidential information.

- I understand that I may ask questions, consult with anyone and review these records before I sign this form.
- This form will only be valid for one year in which a new authorization for release of medical information will be required.
- The facility, its employees and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: ____ Date: ______________
(Participant/Spouse/Guardian)

Program Staff: ____ Date: ______________

(Meets HIPAA Requirements)