RELEASE OF OKLAHOMA PHARMACISTS HELPING PHARMACISTS (OPHP) INFORMATION TO _____

I hereby authorize and direct the Oklahoma Pharmacists Helping Pharmacists (OPHP) program to release any and all copies of reports, evaluations, and information pertaining to the examination, treatment or hospitalization with the OPHP program.

A copy of this medical authorization shall have the same force and effect as the original.

Dated this _____ day of _____, 20___, in _____ County, State of Oklahoma.

I understand that my records are protected under Federal and State Confidentiality Regulations and cannot be released without my written consent unless otherwise provided for. I may revoke this consent at any time. If not previously revoked, this consent will terminate upon successful completion of my recovery monitoring agreement with Oklahoma Pharmacists Helping Pharmacists.

I further acknowledge that the information to be released was fully explained to me and my consent is given of my own free will.

_____ _____

Witness **Pharmacist's Signature**

Revised 9/11