OKLAHOMA
Medical Marijuana
Authority

AUTHORIZATION TO DISCLOSE PATIENT INFORMATION

IMPORTANT: This form is to be completed by the licensed patient or the legal representative of the patient.
This form authorizes disclosure of medical marijuana patient information in the state of Oklahoma.

PATIENT INFORMATION

First Name ______ Middle Name ______ Last Name ______ Suffix ______

Medical Marijuana Patient License # ______ Date of Birth (mm/dd/yyyy) ______

Proof of Identity (select one): ☐ OK Driver's License ☐ U.S. Passport/U.S. Photo I.D. ☐ OK I.D. Card ☐ Tribal I.D. Card

Proof of Identity Documentation # (e.g. Drivers License number): ______

INFORMATION TO BE SHARED

(select all that apply):

☐ Entire Patient Record ☐ Patient Application for Licensure ☐ Physician Recommendation Form ☐ Physician Termination of Patient License Form

☐ Patient Surrender of License Form ☐ Patient Information compiled between ______ (mm/dd/yyyy) and ______ (mm/dd/yyyy)

☐ OTHER: ______

The information may be disclosed for the following purpose(s) only *(select all that apply):*

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At My Representative's Request

☐ OTHER: ______

ATTESTATION *I understand that by voluntarily signing this authorization:*

- Pursuant to 63 O.S. § 427.7(C), I authorize the Oklahoma Medical Marijuana Authority to disclose my patient records as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to disclose information, I can revoke this authorization at any time. The revocation must be made in writing and delivered to the Oklahoma Medical Marijuana Authority in accordance with the instructions below.
- I understand that signing this authorization will not affect my eligibility for licensure with the Oklahoma Medical Marijuana authority.
- I understand that I cannot restrict information that may have already been shared based on this authorization.
- Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by 63 O.S. § 420, 63 O.S. § 427.7, and 63 O.S. § 427.22.
- The information in this recommendation form is true and correct.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: ______

Signature of Patient, Parent or Legal Representative ______ Date mm/dd/yyyy ______

Description of Legal Representative's Authority ______ Expiration Date (mm/dd/yyyy) If longer than one year from date of signature or no event is indicated ______