PEER ASSISTANCE PROGRAM
P.O. Box 52926
Oklahoma City, OK 73152

http://www.oklahoma.gov/nursing

OKLAHOMA BOARD OF NURSING
Phone: 405/525-2277
Fax: 405/525-0350

Participant's Name:_____

Release of Information:

I,hereby authorize _____ (practitioner's name) to disclose to the Peer Assistance Program, including staff and Peer Assistance Committee members, any and all information relating to Participant's medical treatment that may be requested by the Peer Assistance Program.

_____ _____

Participant's signature ***date*** ***Witness' signature*** ***date***

MEDICATION REPORT

This form must be completed & submitted directly to the Peer Assistance Office **by the Prescribing Practitioner**, via **MAIL** or **FAX**. ***This form will NOT be accepted if it is submitted by the Participant.***

If you have any questions, please call the Program Office.

PRESCRIPTION AND/OR ADMINISTERED MEDICATION INFORMATION (please print)

Date of RX/Administration	Name of Medication	Dosage	Amount Prescribed/ Administered	Number of Refills	Reason Prescribed/Administered

I have been informed this Participant is in recovery for a substance use problem. I am aware that the continued use of mind-altering, potentially addictive substances increases the risk of relapse for individuals in recovery.

_____ (_____)_____

Practitioner Name (Please Print) Phone

_____ _____

Practitioner Signature Date

Revised: 10/24/07; 9/19/17; 6/19/19; 12/4/19