

Date: _____

Case name: _____

Case number: _____

Request for Release of Medical Information

The Oklahoma Human Services (OKDHS) Energy Assistance program requires the following information to determine eligibility for the life-threatening energy crisis assistance program. You have the right to supply the information yourself. If you want OKDHS help, please complete this form.

Client Permission and Signature

I give permission to OKDHS to access information from your records that may be needed to determine eligibility for the following persons:

Patient name	Social Security number	Date of birth

I understand I may withdraw this consent in writing at any time. This consent expires six months from the date of my signature.

 Client, guardian, or parent signature

 Spouse signature

 Date

Worker Contact Information

 Worker name

 Email address

 Phone number

 Fax number

 Date

Medical Equipment

Does the patient have a medical condition that requires prescribed equipment for treatment? ☐ Yes ☐ No

Does the prescribed equipment require electricity to work? ☐ Yes ☐ No

Would it be life-threatening for the patient if the prescribed equipment were not operable due to a power outage? ☐ Yes ☐ No

Does the prescribed equipment have a battery backup in case of a power outage? ☐ Yes ☐ No ☐ I don't know

Would the battery on the prescribed equipment be sufficient for treatment in case of a power outage? ☐ Yes ☐ No ☐ I don't know

Can the battery for the prescribed equipment be charged in a different location in case of a power outage? ☐ Yes ☐ No ☐ I don't know

Refrigerated Medication

Does the patient have a medical condition that requires a prescribed medication for treatment? ☐ Yes ☐ No

Does the prescribed medication need to be refrigerated? ☐ Yes ☐ No

Would it be life-threatening for the patient if they did not have the prescribed medication? ☐ Yes ☐ No

Additional Information

Additional information you wish to provide:

Signatures

I attest that the above information is an accurate description of my patient's medical circumstances.

Licensed health care provider signature Date

Licensed health care provider name Health care institution name

Email address Phone number Fax number

Address City State  Zip code