PEER ASSISTANCE PROGRAM
2901 N. Classen Blvd., Suite 101
Oklahoma City, OK 73106

www.ok.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 medical treatment that may be requested by the 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**.

It may be **MAILED** or **FAXED**. ***This form will NOT be accepted if it is submitted by the Participant.***

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

PRESCRIPTION INFORMATION (please print)

Date of RX	Name of Medication	Dosage	Amount Prescribed	Number of Refills	Reason Prescribed

I have been informed this patient is in recovery for chemical dependency. 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 tw