

PEER ASSISTANCE PROGRAM
2915 N. Classen Blvd., Suite 215
Oklahoma City, OK 73160

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