Consent for Client Contact and Verification of External Payments and Referrals

I. INDIVIDUAL INFORMATION (Who May Be Contacted by Tulsa CARES - "The Client")

Name_____ Date of Birth_____

Address _____ City_____

Email address_____ State_____ Zip_____

Area Code & Telephone Number_____ Other Phone Number_____

Check and initial the ways Tulsa CARES can contact you:

_____ ☐ Tulsa CARES may contact me at the address listed in Part I to discuss my care

_____ ☐ Tulsa CARES may contact me at the phone number(s) listed in Part I to discuss my care

_____ ☐ Tulsa CARES may contact me at the email address listed in Part I to discuss my care

_____ ☐ Yes! I want to receive regular updates about Tulsa CARES services and events by:

☐ mail, ☐ phone, ☐ email

II. AUTHORIZATION FOR TULSA CARES PAYMENT OF SERVICES ON MY BEHALF

I authorize Tulsa CARES to contact the providers below when I have been approved for financial assistance for dental, eye glasses, prescriptions, or medical copays, or if I want Tulsa CARES to help me get holiday gift or holiday food assistance. Disclosure of my information will only be limited to my contact information provided in Part I, with the exception of Salvation Army and Oklahomans for Equality. If I wish to receive a holiday basket from Salvation Army or Oklahomans for Equality, Tulsa CARES may also the names and dates of birth of my household members as listed in my Tulsa CARES file. If I wish for other personal information to be exchanged between Tulsa CARES and these providers on my behalf, I will need to complete a separate "Consent for Exchange of Confidential Information" form.

Person/Organization Authorized to Receive Payment or Referrals by Tulsa CARES on My Behalf:

_____ ☐ Dr. Zoellner (for financial assistance by Tulsa CARES for my eye care)

_____ ☐ Couch Pharmacy (for financial assistance by Tulsa CARES for my prescriptions)

_____ ☐ Walgreen's Pharmacy (for financial assistance by Tulsa CARES for my prescriptions)

_____ ☐ Salvation Army Holiday Program (for a holiday gift or food basket for my family)

_____ ☐ Oklahomans for Equality Fairy Tree Holiday Program (for a holiday gift or food basket for my family)

_____ ☐ Other: _____

This authorization expires on: _____ _____
Date Time

Expiration should meet the needs of the client, which usually range between 90 days to 365 days. Authorization cannot exceed 365 days.

I understand that payment for services on my behalf sent to these providers listed in Part II could give another agency or person information that would confirm I have been receiving services from Tulsa CARES.

_____ _____
Signature of Client/Guardian Date

_____ _____
Printed Client/Guardian or Legal Rep. Name Signature of Witness Date