GEORGE HAWKINS
MEMORIAL TREATMENT CENTER
10320 North Airport Road
Clinton, Oklahoma 73601
1-800-247-4612 ext. 32370
Local: 580-331-2370
Fax: 405-422-8282

HEALTH EXAMINATION REPORT

FULL NAME	DATE OF BIRTH
ADDRESS | CITY, STATE, ZIP	SS#:

PLEASE HAVE THE FOLLOWING COMPLETED BY A PHYSICIAN OR THEIR DESIGNEE

	YES	NO		YES	NO		YES	NO
Diabetes			Tuberculosis			Asthma		
Operations			Heart Troubles			Sinus Trouble		
Fractures			Fainting Spells			Skin Disease		
Head Injury			Epilepsy			Hernia		
Back Injury			Mental Disease			Chronic Back Pain		
Other Injuries			Jaundice			Rheumatism		

Relevant Medical History for Residential Treatment

Physical Readings:

HEIGHT	WEIGHT	BLOOD PRESSURE	TEMP
PULSE	RESPIRATION	LUNGS	ABDOMEN
EXTREMITIES		OTHER SIGNIFICANT FINDINGS	
EARS		EYES	
TEETH		NOSE/THROAT	
SKIN		HEART	
SCARS		PREGNANT?	
ACTIVE CASE OF TUBERCULOSIS?		ACTIVE CASE OF HEPATITIS	
ALLERGIES		LIMITATIONS	
WORK SAFE FOR KITCHEN DUTY? IF NO PLEASE EXPLAIN:			

PLEASE ATTACH THE TB/PPD SKIN TEST REPORT AND HEPATITIS PROFILE REPORTS

AS A PHYSICIAN, I CERTIFY THE ABOVE INFORMATION IS TRUE AND CURRENT

SIGNATURE OF PHYSICIAN	DATE
PRINTED NAME OF PHYSICIAN	CONTACT NO:

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RELEASE OF INFORMATION

I, _____, _____,
Client/Applicant's First, Middle, and Last Name *Date of Birth (MMDDYYY)*

hereby voluntarily authorize GEORGE HAWKINS MEMORIAL TREATMENT CENTER to release or exchange client information to:

The information is to be released by:	And is to:
NAME OF FACILITY George Hawkins Memorial Treatment Center	**NAME OF PERSON/ORGANIZATION/FACILITY**
ADDRESS 10320 N. Airport Road	**ADDRESS**
CITY/STATE/ZIP Clinton, OK 73601	**CITY/STATE/ZIP**

The purpose or need for the disclosure is:
☐Further Medical Care ☐Attorney ☐School ☐Personal Use ☐Insurance ☐Disability ☐ Legal
☐ Other (Specify)_____

Specific Information to be released:

_____

_____

_____

Purpose of release:

_____

_____

THIS MUST BE SIGNED AND A COPY MIST BE INCLUDED WITH ANY CORRESPONDENCE.
Including information that will be mailed/sent/faxed to ICW/DHS, etc.

I understand that the records requested may be protected under C.F.R.42 Part2. Governing Alcohol and Drug Abuse Patient Records and State Confidentially Laws and Regulations cannot be released without my consent unless otherwise provided for by the regulation. Any refusal to sign a release of information will in no way affect my ability to receive services nor will it cause me to be refused services. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows.

_____ _____
Signature of Client or Applicant Date

This box is for NOTARY use only – I.D. is REQUIRED for notarization.

State of: _____

County of: _____ NOTARY

Subscribed and sworn to before me on this _____ day of _____, 20 _____. SEAL

NOTICE OF RECIPIENTS OF ALCOHOL AND DRUG ABUSE RECORDS

Each disclosed sheet of information shall contain the following statement stamped in RED: "This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2) The federal rules prohibit you from making any further disclosure of this information unless further disclosure expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. This authorization for release of information may be considered as an original in instances of fax transmittal with notary signature (see below).