

**OKLAHOMA DEPARTMENT OF REHABILITATION SERVICES
OKLAHOMA LIBRARY FOR THE BLIND AND PHYSICALLY HANDICAPPED
PATRON TESTIMONIAL
RELEASE OF PRIVACY INTEREST CONSENT
(This form is voluntary)**

Name: _____ Disability Type: _____

Mailing Address: _____

City, State, Zip: _____ County: _____

Phone: _____ Email: _____

I give permission to use this information to educate the public and the Oklahoma Legislature and/or the U.S. Congress about library services and how they impacted my quality of life. I hereby authorize DRS and the OLBPH to use the information on this form for such purposes. I am a person over the age of 18. I hereby release Oklahoma DRS and OLBPH, its authorized agents and assigns from any and all liability or claims arising out of the use of my name and the information provided on this form. Emailing this form to olbph@okdrs.gov indicates that you give permission to use the information without a signature. Or please sign the form when you return it by mail to Oklahoma Library for the Blind and Physically Handicapped, 300 NE 18th Street, Oklahoma City, OK 73105-3212.

Signature: _____ Date: _____

OLBPH Services Provided:
(check all that apply)

<input type="checkbox"/> Reading Enjoyment	<input type="checkbox"/> Reader Advisor Assistance	<input type="checkbox"/> Book Player Maintenance
<input type="checkbox"/> Book Circulation	<input type="checkbox"/> Magazine Circulation	<input type="checkbox"/> OK Telephone Reader
<input type="checkbox"/> Braille and Audio Reading Download (BARD)	<input type="checkbox"/> Other (please list): _____	

I would be willing to talk with my legislators at the Disability Awareness Day at the State Capitol.

Share your testimonial about how the OLBPH has helped you: (Compare your situation before and after receiving library services: return to the joy of reading, new way of accessing printed materials, greater independence and quality of life or a means to information leading to employment.) _____

(if needed, you may provide more pages)

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