PERMISSION TO RELEASE
MEDICAL RECORDS & MEDICAL INFORMATION

I understand that The Aurora Clinic will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ Home: _____ SS#:_____

I authorize information to be released FROM:

Name of Facility/Doctor: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone:_____ Fax: _____

I authorize information to be released TO:
The Aurora Clinic
1847 East Burnside Suite B
Portland, OR 97214
This information will be used for the following purposes:
X Patient Care _____ Legal Review (Type of injury and Date)
X Medical Review

INITIAL on all lines below for type of information to be released:
_____ ALL Records (Limited to 2 years) pertaining to my diagnosis of: _____
_____ Physician Notes and Records (Limited to 2 years - EXCLUDES protected records unless initialed below)
HIV/Aids Information _____ Drug/ Alcohol Information _____ Psychiatric Data _____

Expiration: Unless revoked in writing, this authorization expires 180 days from the date of signature.
Faxing Limits: Please limit faxed records to 20 pages. All other records may be submitted by mail in hard copy or digitally as a PFD on a CD. Please DO NOT send X-Rays, MRIs or X-Ray film. The Aurora Clinic does not pay for medical records.
Disclosure Statement: I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of the "Sender" or you. This information may not be protected by Federal privacy regulation
Revocation: This Authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or other have acted in reliance upon this Authorization.
Disclaimer: Your general medical information may contain references to your mental state, drug and alcohol condtions, or HIV status or sexually transmitted diseases. Release of this information in your general medical record requires additional authorized signatures.
Fax Authorization: I specifically give authorization to FAX my medical information. I understand risk involved in faxing records and confidentiality at the receiving end cannot be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information.

_____

Patient's Signature (OR Legally responsible person- state relationship to patient)

_____

Date

PH: 503.232.3003 FAX: 503.389.1583

Our doctors cannot treat or diagnose any medical condition that you may have. That is the job of your Primary Care Physician—An M.D., D.O, Therapist, Naturopath, Chiropractor or Acupuncturist. Our doctors will be able to determine your eligibility for the OMMP card based on those existing records.

At initial contact, we will ask if you have existing medical records. Our doctors need to see Full Chart Notes that show your qualifying condition, a medical history and a recent physical exam. These records must be from within the last 12 months.

Once our doctors have reviewed your records, we will contact you with the doctors' decision. With an approval, we can set up an appointment. At that appointment, you will meet with a doctor who will conduct a brief physical exam and complete the supplemental paperwork that the OMMP requires. You will receive information about the risks and side effects of Marijuana use and we will help answer any medical related questions you may have.

Costs

Clinic Service (Cash, debit, or credit card)

Once we call to schedule, if you pay at least one business day before your appointment, you can save up to 40$ after getting your approval.

--if you pay at least one day ahead of your appointment, the cost is $185.00

--if you pay at your appointment, the cost is $205.00

Optional Service: We can mail your completed paperwork to the OMMP as soon as your appointment with us is finished. We will provide you with copies of the paperwork that is mailed to the OMMP along with a certified mail receipt. You would be legally protected for possession (and growing, if the grower/growsite section of the application is filled out) of medical marijuana. ORS 475.309 (9) Rev 02/2014, Certified Mail cost is $20.

State Patient registration (in the form of a check or money order)

Standard fee is $200.00, but discounts are available if you receive any of the following benefits:

Proof of Food Stamps: $60.00

Proof of Oregon Health Plan: $50.00

Proof of SSI (supplemental security income) $20.00

Veteran status (Honorably discharged) $20.00

No additional cost to add a caregiver, $200 to add a grower other than yourself, or if you are growing away from your residence.

Oregon Medical Marijuana Qualifications

You must have a debilitating condition as described by the State of Oregon. These include, but are not limited to:

Cancer

Glaucoma

HIV/AIDS

Post-Traumatic Stress Disorder (PTSD)

A degenerative or pervasive neurological condition

Other symptoms that produce one or more of the following symptoms also qualify:

Cachexia (Inability to maintain a healthy weight)

Severe pain

Severe Nausea

Seizures, including but not limited to seizures caused by epilepsy

Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis

Important info:

The OMMP is the authority of all rules and regulations for registration. Their contact number is 971.673.1234

Please review the OMMP Handbook on-line:

https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Documents/ed-materials/app.handbook.pdf