The Aurora Clinic
1847 East Burnside, Suite
B Portland, Oregon 97214
Phone: 503.232.3003 Fax: 503.389.1583
info@theauroraclinic.com
www.theauroraclinic.com

To qualify for the Oregon Medical Marijuana Program (O.M.M.P.) you must have a debilitating medical condition, diagnosed by an M.D. or D.O. Debilitating medical conditions that qualify for OMMP are: Alzheimer's Agitation
Cancer
Glaucoma
HIV/AIDS

OR you are being treated for any of these conditions:
Cachexia (wasting syndrome,)
Severe Pain,
Severe Nausea,
Seizures, not limited to Epilepsy; or
Persistent Muscle Spasms, not limited to Multiple Sclerosis

For an appointment at The Aurora Clinic, you will most likely need current records provided by a Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP) or a Physician Assistant (PA). Current records from a Chiropractor, Acupuncturist, or Naturopath may be accepted, if they document on-going treatment (more than one visit).

Current Massage Therapy or Physical Therapy Records for on-going treatment, which are backed up by older records from MD & DO, may also qualify for an appointment. Please limit this to a few pages. You can bring other pertinent medical records to the clinic at the time of your scheduled appointment. To obtain your records please use the release form provided by The Aurora Clinic. If you have any problems, let us know and we'll do what we can to assist you. Additionally we provide counseling regarding methods of harm reduction and the parameters of the law.

The cost of our clinic is $195. We offer two discounts: if you can get your medical records in at least 48 hours ahead of time then you get $20 off, and if you pre-pay for your appointment at least 24 hours ahead then it's another $20 off. So it would be $155 with both of those discounts.

We look forward to serving
you.

The Aurora Clinic.

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: _____
Street Address: _____
State: ____ Zip: _____Phone_____ FAX:

I authorize information to be released TO:
The Aurora Clinic
1847 East Burnside, Suite B
Portland, Oregon 97214
Phone: 503.232.3003 Fax: 503.389.1583
This information will be used for the following purposes:
__X__ Patient Care _____ Legal Review (type and date of injury)
X Medical Review Other

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 PDF 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 others have acted in reliance upon this Authorization.

Disclaimer: Your general medical information may contain references to your mental state, drug and alcohol conditions, 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 the 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