



**Mothers Against Misuse and Abuse**  
Mail: PO Box 1776 The Dalles, OR 97058  
Phone: 503-233-4202 or 541-298-4202 FAX: 1-866-559-3369  
clinic@mamas.org

Thank you for your inquiry about MAMA's Medical Marijuana Clinic. We specialize in helping patients understand the Program's registration process, get needed medical records and schedule appointments with doctors knowledgeable about cannabis therapeutics.

To qualify for the Oregon Medical Marijuana Program (OMMP) you must have a debilitating medical condition diagnosed by a *Medical Doctor* (M.D.) or *Doctor of Osteopathy* (D.O.).

Debilitating medical conditions that qualify for the OMMP are:

**Cancer, Glaucoma, HIV/AIDS, A degenerative or pervasive neurological condition, Post-Traumatic Stress Disorder (PTSD)**, or treatment 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 MAMA's clinics, you will need current medical records. These will be accepted from an *M.D.*, *D.O.*, *Nurse Practitioner* (N.P.), or *Physician Assistant* (P.A.)

Current records may be accepted that document on-going treatment (more than one visit) from a *Chiropractor, Acupuncturist, or Naturopath*.

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 MAMA's Medical Records Release form to have a doctor send your records to our doctor.

**We offer clinic appointments in Portland, The Dalles and Bend.**

The cost of our clinic for a NEW Patient is **\$220** and for a RETURN Patient is **\$205**.

**A nonrefundable, \$50 deposit is required when your appointment is set, with balance due the day of the clinic.**

We accept payment through debit or credit cards, money orders or cash.

**MAMA does not accept checks.**

At your appointment we provide counseling regarding methods of harm reduction and the rules of the OMMP.

We look forward to serving you,

MAMA Staff

**Mothers Against Misuse and Abuse Clinic**  
PO Box 1698 The Dalles, OR 97058 phone: 503-233-4202 OR 541-298-4202

**PERMISSION TO RELEASE MEDICAL RECORDS & MEDICAL INFORMATION**

Please fill out this form carefully and completely. Much of the information is REQUIRED by Federal and State Law to comply with your release request.

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:*

**MAMA Clinic - Medical Records Dept.**  
PO Box 1698  
The Dalles, OR 97058  
Phone: 541-298-4202 Fax: 1-866-559-3369  
[records@mamas.org](mailto:records@mamas.org) <http://www.mamas.org>

*This information will be used for the following purposes:*

Patient Care                      \_\_\_\_\_ Legal Review (type and date of injury)  
 Medical Review                      \_\_\_\_\_ Other \_\_\_\_\_

**INITIAL** - 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 of information and excludes protected records.)  
\_\_\_ HIV / Aids Information  
\_\_\_ Other (specify information and dates) \_\_\_\_\_

**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. **MAMA does not pay for 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.

**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

09-12-16

## The Oregon Medical Marijuana Program fees are as follows:

**Basic cardholder application and annual renewal fee: \$200**

**Reduced application and annual renewal fee:**

- for Oregon residents receiving **SNAP (food stamp)** benefits: **\$60.**
- for Oregon residents currently enrolled in the **Oregon Health Plan (OHP): \$50.**
- **Veterans who have served in the Armed Forces of the United States: \$20.**
- Persons receiving **Supplemental Security Income (SSI)** benefits: **\$20**

**NOTE:** *Social Security Retirement Income* and *Social Security Disability Insurance* benefits *do not qualify* an applicant for this reduced fee.

**If you are eligible for more than one reduced fee, please only submit proof for one.**

You may choose the lowest fee you are eligible for. Do not submit proof for more than one reduced fee, as this may slow down the processing of your application.

**Grow site registration fee (paid for by grower)** on new or renewal applications where the patient **is not his or her own grower: \$200.**

- **Note:** Effective 4/1/2016, the grower fee is \$200. The grower pays this fee and should go to the *Growers page of the OMMP website* for more information and payment.

**Fee for replacement registry cards: \$100 (or \$20** for those patients who qualify for the \$20 reduced application fee). A replacement card fee is required if your cards have been issued and you are changing your care giver, grower, or grow site; OR if you are requesting new registry cards that have been lost or stolen

OMMP fees are **non-refundable.**