



**The Hemp and
Cannabis Foundation**
Legalize. Regulate. Educate.

PATIENT INFORMATION

We've helped certify over 50,000
qualified patients for medical cannabis,
and we hope we can help you.

Portland, OR – THCF Main Office

105 SE 18th Avenue, Portland, OR 97214

Phone: 503.281.5100 Toll-Free: 800.723.0188 Medical Records Fax Line: 503.235.0120

Grants Pass, OR Office

558 NE F Street #1, Grants Pass, OR Phone: 541.244.4000 Fax: 541.244.4004

Bellevue, WA Office

1813 130th Avenue NE, Suite 210, Bellevue WA 98005 Phone: 425.869.6186 Fax: 425.869.6378

Spokane, WA Office

225 E 3rd Avenue, Spokane, WA 99202 Phone: 509.321.2272 Fax: 509.321.2270

Denver, CO Office

2420 W 26th Avenue, Denver CO 80211 Phone: 303.403.9996 Fax: 303.403.9998

We occasionally travel to Durango or Glenwood Springs; contact the Denver office for details

Riverside, CA Office

647 N Main Street #1D, Riverside CA 92501 Phone: 951.782.9898 Fax: 951.782.9889

Southfield, MI Office

28384 Franklin Road, Southfield, MI 48034 Phone: 248.353.2337 Fax: 248.353.2372

We travel to a number of locations, such as Grand Rapids, Kalamazoo, Flint, Saginaw, Lansing, Marquette, Ann Arbor, Traverse City; contact the Southfield office for details

Scottsdale, AZ Office

7150 E Camelback Road Suite 444, Scottsdale, AZ 85251

Hawai'i

We travel to Hawai'i several times a year, although we do not have a permanent office there. Call for details.

Away Clinics

Our doctors also visit these towns regularly.

OREGON: Bend, Brookings, Eugene, Pendleton

WASHINGTON: Bellingham, Kennewick, Olympia, Port Angeles, Wenatchee

Qualifying Conditions

These vary a little by state, but basically they are:

--cancer

--glaucoma

--HIV/AIDS

--chronic severe pain, including fibromyalgia, migraines, arthritis, degenerative disk or joint disease, and diabetic neuropathy

--seizure disorders, such as epilepsy and Tourette's syndrome

--multiple sclerosis or other muscle spasm disorders, such as cerebral palsy or Parkinson's disease

--chronic severe nausea, including hepatitis C with active symptoms

--Crohn's disease, irritable bowel syndrome, ulcerative colitis

--cachexia, wasting syndrome

THE MEDICAL OFFICES OF

**David Dodge, MD • Thomas Orvald, MD
Eric Eisenbud, MD • Paul Ironside, MD • Paul Meyer, MD
Forrest Beck, ND • Shari Allen, FNP**

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated and signed by the patient, or by a person authorized by law to give authorization.

Phone: _____

I authorize: _____ Fax: _____

Doctor/clinic name

to release medical information for:

Patient's Full Legal Name: _____ **Date of Birth:** _____

Patient's Telephone Number: (_____) _____
Area Code

to the offices of the doctor(s) listed above. Information will be used for continuity of patient care relating to the following medical condition(s): _____

By INITIALING NEXT TO THE Xs BELOW, I specifically authorize the release of the following:

**INITIAL
HERE**

- _____ Clinician office chart notes (**regarding condition above**)
- _____ Diagnostic imaging reports (**regarding condition above**)
- _____ *HIV/AIDS-related records
- _____ *Mental health records
- _____ *Drug and alcohol-related records

***Must be initialed to be included with other documentation**

**INITIAL
HERE**

PERMISSION TO FAX INFORMATION:

YES _____

I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot be guaranteed. This authorization may be revoked at any time. The only exception is when action has been taken in reliance of the authorization. Unless revoked earlier, this consent will expire 90 days from the date of signing or shall remain in effect for the period reasonable to complete the request. I understand that your office will not condition treatment on signing this document, or failure to do so. I further understand that information disclosed by this authorization will not be subject to re-disclosure without my explicit written permission.

Date: _____ Signature: _____

PLEASE DO NOT FAX MORE THAN 25 PAGES WITHOUT CALLING FIRST!



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Medical Records Cover Sheet – Please write legibly!
If we do not get this information with your records, it may delay the review.
Please use your full legal name as it appears on
your driver's license or state ID card.

Today's Date: _____

First Name: _____

Middle Name: _____

Last Name: _____

Date of Birth: _____

Phone Number(s) with Area Code: _____

State of Residence: _____

State(s) You Want a Permit For: _____

**If you are submitting your records on a CD and you want it returned,
please check this box.**