PATIENT INFORMATION

Main Office

2712 NE Sandy Blvd Portland, OR 97232
Phone: 503.235.4606 Toll-Free: 888.499.8423 Medical Records Fax Line: 503.232.8423

Away Clinics

Our doctors also visit these towns regularly.
OREGON: Bend, Eugene, Grants Pass, Salem, Pendleton
WASHINGTON: Bellevue, Bellingham, Kennewick, Olympia, Port Angeles, Spokane, Tacoma, Wenatchee
HAWAII Call for details

Qualifying Conditions

These vary a little by state, but basically they are:
--Cancer
--Glaucoma
--HIV/AIDS
--Chronic severe pain, fibromyalgia, migraines, arthritis, degenerative disk or joint disease, 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
--Post-traumatic stress disorder (PTSD), Oregon only

SAVE PAPER!

Please fax or send CD rather than printed records

Non-Qualifying Conditions

Unfortunately, these conditions **do not qualify** except in California:
--Depression
--Anxiety
--ADD or ADHD
--Bipolar disorder
--COPD

What to send us to get an appointment for your medical marijuana permit:

Before we can schedule your appointment, we need documentation of your qualifying medical condition in the form of chart notes (also called SOAP or progress notes) from several recent visits with your medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP), podiatrist (DPM), naturopathic doctor (ND), physician's assistant (PA) chiropractor (DC) or optometrist (OD). We would also like any recent imaging reports (from x-ray or MRI). Fill out the Authorization to Disclose Records form (third page of this attachment). Fax or mail it to your doctor's office, or take it there in person. You just need to speak to the receptionist or records clerk. Your doctor's office will then fax the records to us. It is rare that we need more than 20 pages or so. Qualifying records must be less than three years old. **We cannot accept notes from a registered nurse, physical therapist, acupuncturist, massage therapist, etc. After-visit summaries and patient instructions don't have the information we need. Please DO NOT mark or highlight the records!**

Please be sure to include your full name, including middle initial if any, and your phone number with area code. We also need to know what state(s) you are seeking a permit.

After we receive your records, which can take up to 30 days (by law, your doctor's office has that long to send them), we will review them to be sure that you are qualified. This usually takes a day or two. We will then call you to set up an appointment to see one of our doctors.

Your appointment with us could last several hours. (Most last an hour to an hour and a half.)

Fees

	New Patient Fee	Renewal Fee	Low-Income Fee
Hawaii	$250	$250	$175
Portland, Bend or Eugene, OR	$180	$180	$120
All other Oregon clinics	$200	$200	$140
Washington	$150	$125	$150

If you pay in advance, you get a small discount. We accept major credit/debit cards, cash, or money orders; no personal checks. It is very unlikely that your insurance will cover this appointment.

We accept the following as documentation of low income: Proof of being on food stamp program (SNAP). In Oregon, being on Oregon Health Plan also qualifies.

There is also a state registration fee in most states.

We are not a dispensary. No medicine or plants are distributed at our offices.

THE MEDICAL OFFICES OF

David Knox, MD

Main Office: 2712 NE Sandy Blvd • Portland, OR 97232

Phone 503.235.4606 • Toll-Free 888.499.8423• Fax 503.232.8423

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

_____ **X** Clinician office chart notes **NO OLDER THAN 3 YEARS (regarding condition above)**

_____ **X** Diagnostic imaging reports **NO OLDER THAN 3 YEARS (regarding condition above)**

_____ **X** *HIV/AIDS-related records

_____ **X** *Mental health records

_____ **X** *Drug and alcohol-related records

_____ **X** *STD-related records

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

INITIAL HERE

PERMISSION TO FAX INFORMATION: **X 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:** _____

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: _____