Oregon Medical Marijuana Program
PO Box 14450
Portland, OR 97293-0450
(971) 673-1234 (Mon – Fri, 9:00am - 4:00pm)
www.healthoregon.org/ommp

Verbal Release of Information Request

Use this form to request that your cardholder account information may be discussed with the designee listed below over the phone. Please type or print legibly.

PATIENT Legal Name (Last, First, M.)– REQUIRED	
MAILING ADDRESS:	PHONE:

I, the above listed Patient, grant Oregon Medical Marijuana Program employees permission to discuss my account information with the following individual:

DESIGNEE Legal Name (Last, First, M.)– REQUIRED	
MAILING ADDRESS:	PHONE:

- Release of Information requests expire when the registration card expires.
- A new Release of Information must be submitted if a cardholder chooses to renew registration and would like to continue to allow the above designee access to account information.
- The Patient may revoke account access to the designee at any time through written request.
- **This form does not authorize the release of written patient records.**

PATIENT SIGNATURE & DATE – REQUIRED	
PATIENT SIGNATURE:	DATE:

Mail completed request form to: → **OHA/OMMP**
PO Box 14450
Portland, OR 97293-0450