Oregon Health Authority

Request to Verbally Release Information

Use this form to give the Oregon Medical Marijuana Program (OMMP) permission to discuss your (the patient's) cardholder account information by phone with the person (designee) listed below. Please type or print legibly.

PATIENT legal name (last, first, middle) – REQUIRED	Date of birth:
Mailing address:	Phone:

I, the above listed patient, grant Oregon Medical Marijuana Program (OMMP) permission to discuss the following information regarding my account with the below designee.

Specific information to be disclosed: ***(Please be as detailed as possible. Requesting "all information" could delay the response.)*** ____

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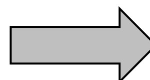
DESIGNEE legal name (last, first, middle) – REQUIRED	
Mailing address:	Phone:

- Release of Information requests expire when the registration card expires.
- A new Request to Verbally Release Information form 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 AND DATE – REQUIRED	
Patient signature:	Date:

Mail completed request form to:



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