

New Patient Information

Greetings,

Welcome to American Heritage Medical LLC. We are Washington's premier medical marijuana specialty clinic, we make it simple and easy 1... 2... 3 for patients with qualifying medical conditions to become legally authorized under RCW69.51A to possess, use, and grow medical marijuana [cannabis].

To schedule an appointment just follow these 3 easy steps

Step 1: Fill out a new patient application; fax it and your medical records to 360-943-7441 for review, [if you need assistance in obtaining your medical records we can help]. Please make sure your paperwork was received by contacting the Olympia Patient Resource Center at 360-456-3517 [Monday - Friday 11am - 6pm]

Step 2: Wait for approval from American Heritage Medical staff; they will contact you to set up an appointment time and date.

Step 3: Come to your appointment and receive your authorization to possess, use, and grow cannabis [marijuana] for medical purposes.

Cost: Unfortunately, medical marijuana authorizations are not yet covered by any private insurance companies, Federal, or State insurance programs, or public assistance agencies. All services must be paid by the patient at the time of appointment.

- The fee for new patients is \$200
- The fee for a renewing patient is \$150 - *[Regardless of where your original Authorization came from]*
Sorry we can not accept personal checks or credit/debit cards at this time.

Patient Information:

Full Name: _____
[First, Middle, Last]

DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Facility/Doctor: _____

Phone Number: _____ Fax Number: _____

Qualifying Conditions: _____

Date last visited: _____

Facility/Doctor: _____

Phone Number: _____ Fax Number: _____

Qualifying Conditions: _____

Date last visited: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I _____ hereby authorize the release of my medical records, chart notes, diagnostic imaging reports, or other health information to American Heritage Medical LLC. This includes the transfer of my records by mail, facsimile, or any other electronic transmission method:

DOB: _____

Daytime Phone: _____

I am aware that the information in my health records may included information relating to Sexually Transmitted Diseases (STD), Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and may also include records regarding drug, alcohol, or mental health treatment

Patient Initials: _____

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 my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law.

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 and may be subject to redisclosure.

Full Name

[First, Middle, Last]

Signature

Date