Authorization Form for the Release of Protected Health Records

Patients Name: ____
Last First MI

Address: ____
Street

____
City State Zip

Date of Birth: ________________
Month/Day/Year

Phone Number: ________________

I, ________________________________ authorize the following practitioner:
(Patient and or Guardian)

____
(Practitioner / office phone # / Fax #)

to release the following requested medical records to Medical Cannabis Consultants, LLC.

Fax # is 401-244-7133

Phone # is 401-667-7778

The medical records may include but are not limited to the following:

(X)	History and Physical	(X)	Treatment Plan
( )	Discharge Summary	( )	Operative Reports
( )	Complete Medical Record	(X)	Consult / Specialist Reports

Your medical records may include information that you may not want released. This is your right and can be protected under state law.
Please read the following and initial as a sign of agreement.

Initial all below:

_____ I understand that medical records described above may include sensitive information relating to Workman's Compensation, HIV, AIDS, psychological diagnosis and the treatment of drug and or alcohol abuse.

_____ This authorization shall become effective immediately and will expire on the following date, event, condition, or in six months from the date signed.

_____ I understand that I can request a copy of this form after I sign it. I may see and request a copy of the information described on this form. I agree to pay any fees associated with the copying of records. I also understand that any review of original medical records will be supervised.

_____ I understand I have the right to revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ I understand that the authorized health information may be electronically communicated.

____ ____________________

Signature of Patient or legal representative Date

This form is used to obtain health care information voluntarily authorized by you.