



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- | | |
|---|---|
| <input type="checkbox"/> When information is received | <input type="checkbox"/> In one year |
| <input type="checkbox"/> In six months | <input type="checkbox"/> In three years |
| <input type="checkbox"/> On date _____ | |

The person named above hereby authorizes Medical Cannabis Clinic of Florida to
Name of Person, Provider, or Facility

- | | |
|--|--|
| <input type="checkbox"/> Request health information from | <input type="checkbox"/> Send health information to |
| <input type="checkbox"/> Discuss health information with | <input type="checkbox"/> Discuss health information with |

The person named above authorizes information to be requested or released by
representatives of

Name Of Person,
Provider, Or Facility _____
Address _____
Phone _____
Fax _____

Scope

- All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- All information regarding care received by patient between the dates of _____ and _____
Starting Date Ending Date
- Other information (specify): _____

Authorization

Printed name of Patient or Authorized Representative

_____ Signature of Patient or Authorized Representative	_____ Date	_____ Signature of witness	_____ Date
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If not signed by the patient, indicate relationship of authorizing person to patient:

- Parent or guardian of minor child
 Guardian or conservator of conserved patient
 Beneficiary or personal Representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

Initial	Date		From	To
_____	_____	Alcohol or Drug Use/Abuse Treatment	_____	_____
_____	_____	Mental Health Treatment	_____	_____
_____	_____	HIV Status or Treatment	_____	_____

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.