PATIENTS fill this out and give to your health care provider.

Medical Records Release and Authorization For Disclosure of Health Information

Patient identification and release statement

Patient name: _____ Phone: _____

Address: _____

Social security number: _____ Date of Birth: _____

I, the undersigned patient, authorize the custodian of records for the following physician or practice to release the information requested below.

Name of doctor, hospital, or clinic: _____

Regular phone: _____ Fax: _____

Information requested

1. Current problem list, abstract, and summary of major medical issues, with specific emphasis on the conditions checked below:

   - ❑ Chronic pain (of at least 6 months duration)
   - ❑ Severe nausea
   - ❑ Seizures
   - ❑ Severe muscle spasms
   - ❑ Wasting syndromes
   - ❑ Cancer
   - ❑ Glaucoma
   - ❑ HIV or AIDS
   - ❑ Hepatitis C
   - ❑ ALS (Lou Gehrig's disease)
   - ❑ Inflammatory (*not* irritable) bowel disease
   - ❑ Alzheimer's dementia
   - ❑ Nail patella syndrome
   - ❑ Post traumatic stress disorder

2. Current medication list and drug allergies
3. Laboratory or written radiology results associated with the current problem list
4. Prior two visits for condition(s) checked above
5. I specifically authorize disclosure, if present, of diagnoses associated with HIV, cancer, drug or alcohol abuse, and infectious disease.

Signature

This authorization shall expire one year from the date of this request. I understand that after the custodian of records discloses my health information, privacy laws may no longer protect such information. I also understand that this authorization is voluntary. By signing below I warrant that I have authority to sign this document and authorize the use and disclosure of protected health information.

Please check one of the following:

- ❑ I am signing as the patient.
- ❑ I am signing as a representative of the patient by virtue of legal guardianship or power of attorney.

Signature: _____ Printed name: _____

Date signed: _____

Please send requested information to the following practice (fax or email preferred)

Maine MMJ Physician Services
PO Box 24
Friendship, ME 04547
Fax number: (207) 517-0547 / Email: records@maine-mmj.com / Office number: (800) 563-1531