Patient consent to disclose personal health information (PHI) form

Patient Name: _____ D.O. B: _____
Phone Number: _____ Email: _____
Address: _____

I_____, consent the release of personal health information (PHI) by way of unsecured email. I recognize that other options have been made available to me by way of secure fax directly to the office.
Initial_____

I_____, understand that sending personal health information through unsecure email is not necessarily at a high risk of diversion, but this risk is considerably lowered when sending personal health information by way of secure fax
Initial_____

I_____, give authorization to share my personal health information with the physician/nurse practitioners' clinic to which I wish to have an assessment.
Initial_____

I_____, understand the purpose for disclosing this personal health information and I understand that I can refuse to sign this form.
Initial_____

I hereby release the assessing physician, nurse practitioner, his/her clinic, my family physician and any other involved physician from any and all actions, claims, causes of actions, complaints (even by family and friends) and demands for damages, loss, or injury whatsoever arising directly or indirectly as a consequence to my use of medical cannabis and my application to possess medical cannabis

Signature: _____ Date: _____

Witness: _____ Date: _____

TREATMENT AGREEMENT AMONG PHYSICIAN/NURSE PRACTITIONER AND PATIENT
FOR PATIENTS PURSUING MEDICAL CANNABIS DOCUMENT

I,_____, understand that this Release and Acknowledgement contains important information about medical cannabis the assessing physician/nurse practitioner requires that I acknowledge and understand before he/she may issue a prescription and/or authorization for use of medical cannabis.

I further understand that the consulting physician/nurse practitioner will not necessarily be assuming care for me. He/she will however, assess and evaluate the appropriateness of my request to use medical cannabis to assist in treating the conditions and associated symptoms that I believe; from my own personal experience and research, medical cannabis to be helpful in treating.

I therefore confirm that the assessing physician/nurse practitioner will be my medical practitioner for the sole purpose of medical cannabis authorization and/or prescriptions.

I agree not to make any claim or commence any legal proceeding against the assessing physician/nurse practitioner, his/her practice, my family physician or any other involved physicians (such as specialists) in relation to:
a) my use of cannabis as a medicine; and
b) my application, or prescription for possessing, obtaining and using medical cannabis.

I understand physician/nurse practitioners generally agree that medical cannabis:

- May distort perception (sight, sounds, touch, time)
- May impair memory and learning
- May impair coordination (avoid driving 4 hours after inhaling and 8 hours after ingesting)
- May impair thinking and problem-solving
- May increase heart-rate and reduce blood pressure
- May increase anxiety, fear, distrust or panic

I am aware there is considerable debate and a great lack of consensus among physician/nurse practitioners about:

- The appropriate medical use of cannabis
- The appropriate dosage for medical cannabis
- The risks of smoking cannabis as compared to vaporizing or ingesting medical cannabis
- The risks of smoking the whole plant medical cannabis as compared to extracting the medicinally active cannabinoids and medicating with the same
- The long-term health and psychological risks associated with the use of medical cannabis
- The degree to which regular consumption of the medical cannabis:
  a) may contribute to pulmonary infections and respiratory cancer
  b) may damage the cells in the bronchial passages which protect the body against inhaled microorganisms and decrease the ability of the immune cells in lungs to fight fungi, bacteria, and tumor cells. For patients with already weakened immune systems, this means an increased in the possibility of dangerous pulmonary infections, including pneumonia
  c) May weaken various natural immune mechanisms, including macrophages and T-Cells
  d) May correlate in some cases with mental illness, such as bipolar disorder and schizophrenia

I am further aware that the above listed medical conditions are further compounded by the lack of consistency and uniformity in available medical cannabis products. With conventional drug products, I generally consume a medication as a precisely known molecular quantity. I recognize that raw plant medical cannabis does not work this way. I appreciate that I will get varying compositions of different cannabinoids and varying proportions of different cannabinoids from strain of plant to strain of plant and even, to a lesser degree, from plant to plant of the same strain.

I further appreciate that there is a significant uncertainty regarding the consistency of the medical cannabis drug product may medicate with which further complicates and compounds the practical issue of medicating with an inconsistent drug product like medical cannabis.

I am further aware that ingesting a high dose of medical cannabis can cause nausea and disorientation. Despite all these medical concerns debates and practical issues, I honestly believe that for the treatment of my conditions and symptoms, the benefits of medicating with medical cannabis outweigh the risks.

I agree to receive a medical document (prescription) for medical marijuana only from one physician/nurse practitioner. I also agree if purchasing medical cannabis, I will do so from a Licensed Producer otherwise, I will apply to Heath Canada for a Production License – Personal or Designated Grower.

I agree to safely store my medical cannabis so that no other person may access it either deliberately or accidentally. I am aware that young people (under 25 years) may experience psychosis after consuming medical cannabis and will ensure no child or young person will be exposed to my medical cannabis either directly or indirectly. I will contact Poison Control immediately if any child gains access to my supply of medical cannabis.

I am aware that taking medical cannabis with other substances, especially sedating substances may cause harm and possibly even death. I will not use illegal drugs (cocaine, heroin etc.) or controlled substances (narcotics, stimulants etc.) that were not prescribed for me.

I will inform the physician/nurse practitioner of all controlled substances that are prescribed to me by my regular physician.

I agree to have a medical assessment performed by my regular physician every 12 months.

I am aware that medical cannabis use is not advisable during pregnancy and breastfeeding. I agree to inform my physician/nurse practitioner if I am pregnant. If I become pregnant while being treated with medical cannabis, I will immediately stop using it until I have consulted with a physician.

This is my decision and I also do not support any claims made by my family, friends or other interested parties against said clinic and physician/nurse practitioners.

I hereby release the assessing physician/nurse practitioner, his/her clinic, my family physician, and any other involved physicians from any and all actions, claims, causes of actions, complaints (even by my family and friends) and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence to my medical cannabis and my application to possess medical cannabis.

This release from liability is to be binding on heirs, executors and assigns. I also consent to the disclosure, sharing and use of my personal information and medical data by the assessing physician, his/her clinic and my licensed commercial producer.

I understand and acknowledge that while the assessing physician/nurse practitioner may execute a declaration that I stand to potentially benefit from medical cannabis, the assessing physician/nurse practitioner will not serve as my primary care physician/nurse practitioner. As such I agree to seek regular medical care from my primary care physician and that the assessing physician/nurse practitioner will only deal with assessing his support for my medical cannabis use.

If licensed, I agree not to resell or give away any of my medication. I agree to check with local bylaws in my area.

Patient Name: _____ Witness Name: _____

Patient Signature: _____ Witness Signature: _____

Date Signed: _____ Date Signed: _____
Month Day Year Month Day Year