KARMACANN CONSULTING

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: _____