KARMACANN CONSULTING

Patient consent to disclose personal health information (PHI) form

Patient name: _____ D.O.B _____

Phone number: _____ Email: _____

Address: _____

I _____, consent to the release of personal health information (PHI) to Karmacann Consulting by way of unsecured email. I also recognize that other options have been made available to me by way of faxing my personal health information directly to the office of the physician, to which I am having my medical assessment.

Initial _____

I _____, understand that sending personal health information through unsecure email is not necessarily at a high risk of diversion, but this risk is substantially lowered when sending personal health information by way of fax.

Initial _____

I _____, authorize Karmacann Consulting to share my personal health information with the doctors clinic to which I wish to have an assessment.

Initial_____

I _____, understand the purpose for disclosing this personal health information to Karmacann Consulting and I understand that I can refuse to sign this form.

Initial _____

I hereby release Karmacann Consulting, the assessing physician, his/her clinic, my family physician and any other involved physicians 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: _____