Authorization To Release Medical Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Records May Be Release To: Greenlight Wellness
8445 S. Saginaw St. Suite 103
Grand Blanc, MI 48439
Ph: 877-420-5420 Fax: 248-965-9104
Email: records@greenlightmmj.com

Patient Name:_____ **Date of Birth:** _____

Telephone:_____ **Social Security Number:** _____

I, the undersigned, authorize the release of, or requested access to the information specified below from the medical record(s) of the above named patient.

INFORMATION TO BE RELEASED: [Please only send most recent record pertaining to condition below]

___ History/ Physical ___ Consultation Report ___ Emergency Room Record ___ Progress Notes
___ Operative Reports ___ Discharge Summary ___ Lab/ Path Reports ___Other:_____

Information will be used for the continuity of care relating to the following medical condition(s): [Please check all that apply]

___ Rheumatoid Arthritis/ Arthritis
___ Amyotrophic Lateral Sclerosis
___ Agitation of Alzheimer's Disease
___ Cachexia or Wasting Syndrome
___ Obsessive Compulsive Disorder
___ Rheumatoid Arthritis/ Arthritis
___ Parkinson's Disease
___ Tourette's Syndrome
___ Spinal Cord Injury

___ Rheumatoid Arthritis/ Arthritis
___ Severe and Chronic Pain
___ Rheumatoid Arthritis/ Arthritis
___ Post-Traumatic Stress Disorder
___ Rheumatoid Arthritis/ Arthritis
___Severe/ Persistent Muscle Spasms
___ Ulcerative Colitis/ Colitis
___ Cerebral Palsy
___ Autism

___ Severe Nausea
___ Seizures
___ Cancer
___ AIDS/HIV
___ Hepatitis C
___ Glaucoma
___ Crohn's Disease
___ Nail Patella
___ Other: _____

Please *initial* one or more of the following:

____ You have my permission to **FAX** the requested information.
____ You have my permission to **MAIL** the requested information.
____ You have my permission to **ELECTRONICALLY** submit my records.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. This authorization may be revoked at any time in writing. Unless otherwise revoked, this authorization will expire 12 months from the date of signature. I understand that information disclosed by this authorization will not be subject to re-disclosure without my written consent.

Patient Signature: _____ **Date:** _____