MICHIGAN MEDICAL MARIJUANA CERTIFICATION CENTER

www.YOURGREENOPTION.com

SOUTHFIELD

29777 Telegraph Road | Suite 1451

Southfield, MI 48034

248-932-6400 | Phone **248-932-6362 | Fax**

GRAND RAPIDS

616-452-0899 | Phone **616-608-0551 | Fax**

GAYLORD

989-705-9991 | Phone **989-705-9992 | Fax**

Name: _____ _____ _____
First M.I. Last

DOB: _____

Address: _____

City, ST Zip: _____

Phone: _____ Cell: _____

Email: _____

Location for Appointment: Southfield ☐ Grand Rapids ☐ Gaylord ☐

Qualifying Medical Condition:

- ☐ Cancer
- ☐ Glaucoma
- ☐ HIV/AIDS
- ☐ Hepatitis C
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Crohn's Disease
- ☐ Agitation of Alzheimer's Disease
- ☐ Nail Patella
- ☐ Cachexia or Wasting Syndrome
- ☐ Severe and Chronic Pain
- ☐ Severe Nausea
- ☐ Seizures
- ☐ Severe and persistent muscle Spasms

How Did You Hear About Us? _____

The next step is for our office to obtain and review your medical records from your treating physician. We will fax a confidential records request from **PHYSICIANS CERTIFICATION SPECIALIST THE OFFICE OF DR. GONTE**. Please include your treating physicians name and phone/fax number so we can order your records TODAY!

Physicians Certification Specialist
29777 TELEGRAPH RD., STE 1451
SOUTHFIELD, MI 48034
TEL: (248) 932-6400 FAX: (248) 932-6362

I, _____(**PRINT PATIENT NAME)**

x x x x x

_____/_____/_____, ~~x x x~~ - ~~x x~~ - ___ ___ ___ ___

BIRTHDATE **SOCIAL SECURITY #**

Authorize _____ _____

(Doctor Name) (Doctors Phone or Fax Number)

to release and discuss any and all medical records and medical information that you have for me in your possession regarding my medical condition and my medical treatment, including but not limited to, my medical history, my medical treatment, your findings regarding my medical condition, records of consultations that I have had, records of medication prescribed for me, x-rays taken of me, my radiology reports, and hospital, and medical records to:

Physicians Certification Specialist
29777 Telegraph Road, Suite 1451
Southfield, MI 48034
fax **(248) 932- 6362**

for the sole purpose of medical records review and certification of my medical condition.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is intended to be an unlimited, full, and complete Authorization for the release of any and all protected medical information as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Medical Records Access Act, as amended, and under the rules and regulations thereof, and covers all protected information from primary and secondary providers, health plans, health care clearinghouses, emergency services, financial and administrative transactions, and business associates. A covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b)(4) applies. It is understood that the person to whom this Authorization is given has my permission to use and disseminate this information in his or her sole discretion.

1. **Expiration.** This authorization expires 18 months after patient signed this release.

2. **Right to Revoke.** I have the right to revoke this authorization by signing and dating a written statement revoking this authorization, and it shall become effective on delivery to you. If this authorization is revoked, any person or entity acting in good faith in reliance upon it and lacking actual knowledge of its revocation shall be held harmless.

3. **Redisclosure.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by this rule.

4. **Administrative Provisions.** I revoke any prior authorizations I have made to disclose health information that are inconsistent with this authorization. This document shall be governed by Michigan law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub L No 104-191, and the Medical Records Access Act, MCL 333.26261 et seq. However, I intend it to be honored in any jurisdiction where it is presented and for other jurisdictions to refer to Michigan law and HIPAA to interpret and determine the validity and enforceability of this document. Photocopies or facsimile reproductions of this signed authorization shall be treated as original counterparts. I am providing this authorization voluntarily and have not been required to give it to obtain treatment. I am at least 18 years old and of sound mind.

_____

PATIENT OR LEGAL REPRESENTATIVE'S SIGNATURE **DATE**