BOSTON SOUTH SHORE NATURAL THERAPIES

RELEASE AND REFERRAL FORM

Patient Name: Date:
DOB:

Release (Completed by Patient)
I authorize Dr._____
Address: _____
Phone: _____ Fax: _____

To release to me, my medical information relating to care provided within the last 12 months, including office notes, tests, x-ray results, hospitalizations, treatments, etc. for the purpose of an evaluation leading to possible certification for the use of medical marijuana.

Signature of Patient:_____ Date: _____
Printed Name:_____ Contact #:_____

Referral (completed by doctor)

1) Diagnosis:
2) Status
3) Complications
4) Indication for Medical Marijuana certification
5) Allergies

Status:

The patient has requested an evaluation regarding the possible use of medical marijuana and an adjunctive treatment of their chronic debilitating illness.
Signed: _____ Date: _____

Initia.: ___