

RENEWAL PATIENT ACKNOWLEDGMENT AND DISCLAIMER

1. I/the patient understand that it is my/the patient's responsibility to compile medical records that I/the patient will submit to MMMCC for review. I/the patient declare that the medical records provided to MMMCC for review are my own/the patient's and not those of any other individual; that they are true and accurate; and that they have not been altered to the best of my/the patient's knowledge.
2. I/the patient further understand and acknowledge that it is my sole responsibility to complete the necessary requirements of the application and/or renewal application to the Michigan Medical Marihuana Registry Program and to obtain a Medical Marihuana Registry Identification Card.
3. I/the patient understand that the certification of debilitating medical condition by MMMCC, if any, is based solely upon the medical records and other information provided by me/the patient, that any determination by MMMCC is limited by the sufficiency of such information and the physician's consultation.
4. I/the patient currently have a valid medical marihuana registration identification card issued to me by the State of Michigan Department of Community Health, Medical Marihuana Program, a copy of which is attached to this form.
5. I/the patient have and continue to comply with the Michigan Medical Marihuana Act, MCL 333.26421 (the "MMMA") and all of the rules and regulations as mandated by the Michigan Department of Community Health (MDCH) relating to the Michigan Medical Marihuana Program (MMMP).
6. I/the patient am still a Michigan resident.
7. I/the patient have been diagnosed with a debilitating medical condition as defined by the MMMA.
8. My/the patient's medical condition has not changed in the last year and I continue to suffer from a debilitating medical condition.
9. I/the patient will immediately notify Michigan Medical Marihuana Certification Center (MMMCC) of any changes in my medical condition that may impact the determination that I suffer from a debilitating medical condition as defined in the MMMA.
10. Since being issued a medical marihuana registration identification card last year I have received and continue to receive palliative benefit for my debilitating medical condition and its symptoms through the use of Medical Marihuana.

Patient Signature

Patient Name (Print)

Date

Address: _____

City, ST Zip: _____

Phone: _____

Cell: _____

Email: _____

Medical ID #: _____

Location for Appointment: Southfield Grand Rapids Gaylord

Physicians Certification Specialist
29877 TELEGRAPH RD., STE 303
SOUTHFIELD, MI 48034
TEL: (248) 932-6400 FAX: (248) 932-6362

I, _____ (PRINT PATIENT NAME)

_____/_____/_____,
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
29877 Telegraph Road, Suite 303
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.
5. Any Billing for Medical Records is solely the patient's responsibility.

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