

C.A.R.E.S.

We are establishing a physician-patient relationship to determine whether a recommendation for the safe use of medical marijuana can be made and NOT for any other purpose. You are advised to consult with your primary care provider at least once a year for re-evaluation of the diagnosis and treatment plan.

I, _____ understand that the physician is NOT providing or recommending medical treatment. The physician is evaluating me to determine whether I have a chronic debilitating condition as defined by Article XVIII and SB 109

I, _____ understand that an opinion from the physician that I am qualified for the use of medical marijuana as defined by Article XVIII and SB 109 is NOT a recommendation as to how, when, what form or how much marijuana product I use. While these issues may be discussed at the time of your medical card evaluation, any and all decisions regarding these matters should be made after consultation with your primary care provider.

I, _____ understand that the sole purpose of this examination is to determine whether I am qualified to receive a Colorado medical marijuana card. The evaluation is based on constitutionally outlined conditions and diagnoses as defined by Colorado Constitution Article XVIII and SB-109.

I, _____ understand that the physician evaluating me can only make a provisional diagnosis for my chronic debilitating medical condition. The physician's opinion as to whether I qualify for the use of medical marijuana is based on my medical history, current medical status, drug or medication abuse, physical exam, medical records (if available), form of marijuana used, whether I grow my own plants and my yield per plant.

I, _____ understand that I am NOT receiving a comprehensive medical examination as one would expect from their primary care provider. The examination is limited to factors and/or conditions related to my receiving a medical card allowing me to purchase medical marijuana. It is not intended to replace, supersede and/or modify any treatment or recommendation of my primary care provider.

I, _____ understand that it is my responsibility to ensure that my primary care provider is aware of and approves of my intentions regarding the use of medical marijuana.

I, _____ understand that the physician providing this medical evaluation is available for follow-up care for any and all matters related to my use of medical marijuana.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you have certain privacy rights concerning your health care information. Under this law, your health care provider generally cannot give your information to your employer, or share your information for marketing or advertising purposes, without your written consent. It is important that you understand that your information can be used and shared in the following ways.

- To Inform multiple health care providers who may be involved in your treatment directly and indirectly.
- To inform your family, friends, relatives, or others that you identify, who are involved in your health care or health care bills.
- Threats to health and safety that involves you harming yourself or others
- To make required reports to the police
- To provide information about employees, to employers, regarding worker's compensation
- To obtain payment from third party payers.

I acknowledge that I have received and read a copy of my HIPPA privacy rights. And I agree to have this information released to my medical doctor. (This permission may be revoked at any time!)

Name

Signature

___/___/___
Date