

Medical Marijuana Patient Declaration

I hereby declare that I have completely and truthfully disclosed all information regarding my medical condition and attest that I do not intend to use my medical recommendation for the purpose of illegally obtaining or distributing medical marijuana.

I attest that I am not a member, employer, or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone, or any other recording device be it a still image, video or audio. This is a direct violation of HIPAA regulations and patient/doctor confidentiality.

I am aware that my recommendation can be revoked at any time and legal actions will be taken if I have perjured or misrepresented myself or my condition.

I acknowledge Craig H Greene, MD informed me of the nature of a recommended treatment, including but not limited to risks, complications, expected benefits of any recommended treatment, and likelihood of success or failure.

I acknowledge Craig H Greene, MD informed me of any alternatives to Medical Marijuana treatment, including the alternative of no treatment, and their risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my conditions.

Patient Signature _____ **Date** _____

Release of Liability

I affirm that I have a serious medical condition that negatively affects my quality of life. I have found or am interested in finding out whether or not medical marijuana provides substantial relief or an improvement in my condition.

In requesting approval or recommendation for the use of medical marijuana, I take full responsibility for any and all risks involved in this action.

I am also advised that the use of medical marijuana may affect my coordination and cognition in ways that could impair my ability to drive, operate machinery, or engage in potentially hazardous activities. I take full responsibility for any harm resulting to me and/or other individuals as a result of my use of cannabis.

I, the undersigned, hereby request a consultation by the physician for purposes of determining the appropriateness of medical marijuana treatment. I acknowledge that using cannabis as a medicine has been explained to me and that any questions that I have asked have been answered to my complete satisfaction. The physician, staff, and representatives are addressing specific aspects of my medical care, and unless otherwise stated are in no way establishing themselves as primary care provider. Should an approval be made for my medicinal use marijuana, I understand that there is a renewal date specified by the physician depending on the condition. I understand that it is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.

Furthermore, the undersigned, or anyone action on my behalf, hold the physician and his/her principals, agents, and employees, free of harmless from any liability resulting from the use of medical marijuana.

Patient Signature _____ **Date** _____