Therapeutic Health Clinic
1417 NW 150th St. Edmond. OK 73013. T: (405) 285-0471. F: (405) 418-4136

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name:_____

Date of Birth: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider (Please insert name of provider)

_____ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Therapeutic Health Clinic
1417 NW 150th St. Edmond. OK 73013. T: (405) 285-0471. F: (405) 418-4136

Purpose: I understand that the specific purpose of this Authorization is: Evaluation for Medical Marijuana prescription.

Information to be disclosed: This permits the above provider to disclose the following medical records (check all that applies):

- o All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- o All of my health information described above except for the following:

  _____
- o Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

  _____

Name: Signature Date: