Medical Marijuana Certification / Informed Consent

1. I/the patient have voluntarily submitted my medical records to Downtown Gilbert Healthcare (DGH) for physician review to determine whether I have a debilitating medical condition as defined in the Arizona Medical Marijuana Act (the "Act"), including, a second physician review if, in the sole discretion of DGH, it is necessary to have such independent second physician review. Solely for the purposes of the Acknowledgement and Disclosure any references to DGH shall include an independent second physician reviewer. In no event shall DGH be liable for the acts or omissions of any independent second physician reviewer.
2. I/the patient understand that it is my/the patient's responsibility to compile medical records that I/the patient will submit to DGH for review. I/the patient declare that the medical records provided to DGH 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.
3. I/the patient further understand and acknowledge that it is my sole responsibility to complete all the necessary requirements of the application to the Arizona Medical Marijuana Registry Program and to obtain a Medical Marijuana Registry Identification Card.
4. I/the patient understand that the certification of debilitating medical condition by DGH, if any, is based solely upon the medical records and other information provided by me/the patient, that any determination by DGH is limited by the sufficiency of such information and the physician's consultation.
5. I/the patient understand that DGH and its physicians shall exercise Independent medical decision making to determine whether I/the patient have a debilitating medical condition as defined in the Act and I/the patient acknowledge that DGH and its physicians may determine that I/the patient do not have a debilitating condition as defined in the Act.
6. I/the patient have received information from DGH about the limited scope of the physician-patient relationship for purposes of DGH's determination. I/the patient understand that, unless otherwise stated, the DGH physicians are not my/the patient's treating physicians and that I/the patient should seek ongoing treatment and medical management of my/the patient's disease or medical condition from my/the patient's primary or other treating physician.
7. I/the patient understand that DGH or its physicians are not recommending or advocating for the use of medical marijuana, nor are DGH or its physicians prescribing the use of medical marijuana. I/the patient understand that the DGH certification, if any, should be used in conjunction with the clinical judgment of my/the patient's primary or other treating physician and that my/the patient's or other treating physician should make the final decision to recommend the use of medical marijuana as part of the treatment and management of my/the patients disease and/or medical condition.
8. I/the patient understand that a certification from DGH or its physicians does not provide me/the patient with immunity from criminal prosecution or penalties under the laws of the State of Arizona or the Federal government relating to the use and/or manufacture of controlled substances. I/the patient further understand that DGH certification does not guarantee acceptance by the Arizona Department of Community Health of my application for registration to the Arizona Medical Marijuana Registry.
9. I/the patient have had sufficient opportunity to ask questions and to have my/the patient's questions answered by the DGH physician.
10. I/the patient understand that it is my responsibility to notify DGH upon changes or improvements in my debilitating medical condition, diagnosis or disease, and I/the patient promise to immediately notify DGH upon any change in my debilitating medical condition, diagnosis, or disease.
11. I acknowledge that I am not recording any portion of my visit with DGH, nor do I possess any recording equipment. I understand that DGH does not approve of such action. I further acknowledge that, without express written permission of DGH, it is illegal to film or record in this office with video camera, cell phone, or any other recording device, including still image, video or audio. Any such action is a direct violation of HIPAA regulations and patient-doctor confidentiality. I assume all responsibility for any violation of this Federal Law.

I acknowledge that I have been informed of and fully understand the above: _____ (Initials)

_____ _____

Date Patient Signature