Midori Med
Tel:754-777-8283 Fax 620-679-1788

Authorization for Release of Medical Records

I _____ [patients name]

DOB_____/_____/_____ SSN _____/_____/_____

Authorize release of medical records to:

Midori Med, LLC
20801 Biscayne Blvd. , Suite 403
Aventura, FL 33180
Fax: 620-679-1788

From
Name of Provider: _____ Fax: _____

I hereby authorized release of all medical records and medical information, regarding any and all medical conditions, treatment, including and not limited to my medical history, treatments and findings of specific medical conditions. Records of consultations, x-rays, medications, radiology reports, etc. The purpose of the medical records is to verify my diagnosed medical conditions.

I understand that the information released may include information related to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and alcohol of substance abuse disorder. I authorize release of this 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 [HIPPA] and the Medical Release 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 the authorization is given has my permission to use and disseminate this information in his or her sole discretion.

Redisclosure: This release does not authorize re-disclosure or medical information beyond the limits of this consent. The recipient of this information is prohibited from using the information for other that the stated purpose, and from disclosing to any other party without further authorization. I specifically understand and agree that the re-disclosure requirements set out above will apply to these records.

Validity: I understand that this authorization will expire in one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure above. I agree that any release of information prior to revocation of the authorization shall not constitute a breach of my rights to confidentiality. Florida Law shall govern this document, as well as HIPPA and Medical Records Release ACT.
I have read (or had read to me) this authorization, and I agree to its terms by my signature below. I am at least 18 years of age and of sound mind.

_____ _____
Patients Signature or Authorized Representative Date

_____ _____
Printed name of patient or representative Date

Release of Liability

I understand that the information on this form is factual and correct and any medical history presented or discussed with the doctor is all factual and complete to the best of my knowledge. I do not plan or intend to use my Physician's recommendation for the purpose of illegally obtaining medical marijuana. Solely for verification purposes I authorize Dr. Bruce Rubinowicz to obtain information about my medical condition.

I understand that I must be a Florida resident to obtain an approval or recommendation for medical marijuana.

I affirm that I understand that ingesting THC orally is 50-60 times more potent that smoking and effects can last up to 6-8 times longer. I affirm that the physician has informed me of this and potential side effects of THC and release the physician from liability should I chose Oral ingestion route.

I affirm that I have a serious medical condition that adversely affects my quality of life. I have found or an interested in learning whether medical marijuana will provide me relief of the symptoms, associated with my medical condition, that are adversely affecting my quality of life.

I understand that the cannabis plant is not regulated by the United States Food and Drug Administration and therefore may contain unknown quantities of active ingredients, impurities and/of contaminates. I understand the potential risks associated with an elevated daily consumption of medical marijuana including risks with respect to the effect on my cardiovascular and pulmonary systems and psychomotor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency. I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. In requesting an approval or recommendation for the use of medical marijuana and I assume full responsibility for all risks involved in this action.

I have been advised that medical marijuana poses risks with it's use, and any adverse reactions or events should be reported to the physician. I have also been advised that THC may affect my coordination and cognition that may impair my ability to drive, operate machinery or engage in potential hazardous activities. I assume full risk associated with use of medical marijuana and THC.

Florida's Medical Marijuana Legalization Initiative- Amendment 2, approved November 08, 2016- provides for possession of medical marijuana for the personal medical purposes of the patient, with physician approval or recommendation. It should be made clear that the physician, staff and representative of the practice are not providing medical marijuana, nor are they encouraging and illegal activity in my obtaining medical marijuana.

I, the undersigned, hereby request a consultation by the physician for the purpose of determining if I have a qualifying medical condition. I acknowledge that all aspects of medical marijuana as medical care have been explained to me and detailed in the medical marijuana consent form. The physician has provided no specific recommendations regarding management of my medical condition with medical marijuana. I understand that medical marijuana is not a substitute for ongoing medical care by my treating doctors. Any changes in my ongoing care will be coordinated by my treating physicians. I also understand that the physician providing medical marijuana is not my treating physician, and not addressing any specific aspects of my medical care.

I, the undersigned, hold the physician free and harmless from any liability resulting from use of medical marijuana.

_____ _____

Patient Signature (or representative) Date