AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION
For OHIO MEDICAL MARIJUANA CERTIFICATION

Patients Name: ______________________________ Date of Birth: _________________________
Social Security #: ________________________ Phone #: ______________________________

I request and authorize ____
(Doctor/Provider/Clinic Name and Address)
Phone: _________________ Fax: ____________________
to release healthcare information of the patient named above to:

Advanced Medical Associates
PO Box 330
Lambertville, Mi. 48144
(734) 347-2127 or (419) 474-4700
Fax: (734) 847-4711
www.amaohio.com

This request and authorization applies to healthcare information (Less than 10 pages) relating to the following treatment or condition. Check all that apply.

___ AIDS
___ Alzheimer's Disease
___ Amyotrophic Lateral Sclerosis
___ Cancer
___ Sickle Cell Anemia
___ Traumatic Brain Injury
___ Post-Traumatic Stress Disorder
___ Multiple Sclerosis
___ Spinal Cord Injury Disease
___ Inflammatory Bowel Disease
___ Tourette's Syndrome
___ Glaucoma
___ Hepatitis C
___ Crohn's Disease
___ Chronic Traumatic Encephalopathy
___ Severe and Chronic Pain
___ Intractable Pain
___ Epilepsy or Seizure Disorder
___ Ulcerative Colitis
___ Parkinson's Disease
___ Positive Status for HIV
___Fibromyalgia

I understand that:

1. I have a right to revoke this authorization, except to the extent that information has already been released in response to this authorization.
2. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee.

Patient Signature: ____________________________________ Date: __________________
Print Name: ____

THIS AUTHORIZATION EXPIRES IN SIX MONTHS AFTER IT IS SIGNED.
A FAX/copy of this authorization shall be considered as valid as the original.