Request for Medical Records

	RE:
______________________________ *Name of Health Care Provider or Hospital Medical Records Dept.*	______________________ *Your Name*
______________________ *Address of Provider*	______________________ *Your Date of Birth*
______________________ *City, State and Zip*	______________________ *Your Medical Record Number*
______________________ *Fax Number*	______________________ *Your Phone Number*
Please check here if this is a Partners practice:	______________________ *Your Home Zipcode*

To whom it may concern:

____
Today's Date

Please fax a copy of my medical records covering the previous 12 MONTH only to:

Dr. Tishler c/o *Inhale*MD

23 Loveland Road

Brookline MA 02445

FAX 617.477.8886 Phone 617.477.8886

The purpose of this disclosure is provision of medical care.

Please include:

1. Current problem list, abstract, and summary of major medical issues.
2. Current medication list and drug allergies.
3. Laboratory or written radiology results associated with the current problem list.
4. I give specific permission to release any information of the nature below, UNLESS I have initialed each type:

__ SUBSTANCE ABUSE
__ PSYCHIATRIC/MENTAL HEALTH INFORMATION
__ HIV/AIDS INFORMATION

This authorization will expire sixty (60) days from the date signed. I understand that I make revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon.
I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer protected by HIPAA. Medical care will not be conditioned upon signing this document except to the extent that signing and obtaining records may be necessary to provide such care.

Patient's or Legal Guardian's Signature ______________________________

A patient is entitled to this information per HIPAA privacy rule it allows your office 30 days to provide the records and doctors may not hold medical records because the patient has not paid for services provided. You may charge a reasonable fee for the cost of copying and mailing records – but this request is for a fax of the records only.

PATIENT QUESTIONNAIRE

Personal Information – please include all requested information

Date_________________

Name _________________________________ Date of Birth* ________________Age _____ Gender ____

Address*____

City ________________________State______Zip* _____________

Home Phone ____________________Cell phone*________________________________

E-mail address* _______________________________

SSN*: ______-______-___________

*required information

Medical History - you must enter information here.

Current Medical problems:

Please list all of your current medications:

Please list any medication allergies:

Primary Care Provider:

Name ____________________________

Practice or Hospital _________________

Fax number* _______________________

Work phone* _______________________

E-mail address* _____________________

Referring Provider:

Name ____________________________

Practice or Hospital _________________

Fax number* _______________________

Work phone* _______________________

E-mail address* _____________________

*required information

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Do you have, or have you ever had, any of the following problems:

Heart failure	Yes	No
Atrial fibrillation	Yes	No
Coronary disease or heart attack	Yes	No
Asthma/COPD	Yes	No
Organ transplant	Yes	No
Blood clot	Yes	No

Do you, your siblings, or parents have any of the following:

Bipolar	Yes	No
Schizophrenia	Yes	No
Psychosis	Yes	No

Cannabis History

How often do you use cannabis? _________

How much cannabis do you use? _________(circle one: puffs, grams per day, or ounces per month)

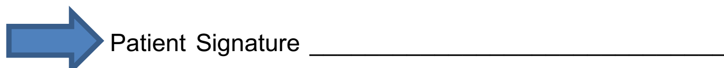
How many times a day do you use cannabis? ____________

Do you use cannabis to reduce or eliminate the use of any medications that have been prescribed for your medical condition? _________ If yes, which medication have you reduced or eliminated?

Additional Information

Please provide any additional information that may be relevant to the physician evaluation:

I understand that the information I have been asked to provide is for the diagnosis and treatment of the medical condition for which I am seeing the physician today, and that if I have not accurately and completely disclosed the requested information, it may adversely impact the physician's ability to diagnose my condition and recommend appropriate treatment. I certify that the information in this questionnaire is accurate and complete.



Patient Signature ___________________________________

Date____

Print Name ____

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PATIENT ACKNOWLEDGEMENT

I understand that:

- The attending physician, staff and/or representatives are neither providing, dispensing nor encouraging me to obtain or use medical cannabis.
- The physician, staff and representatives are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.
- Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the physician. **It is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.**
- I acknowledge that I have not misrepresented any information herein. Any misrepresentation shall lead to termination from the practice, cancellation of any or all appointments, and forfeiture of any and all fees or payments.
- I acknowledge that I am not an agent of law enforcement, State or Federal government here for the purpose of investigation or entrapment.
- I acknowledge that I am not recording any portion of my visit.
- I acknowledge that my continued approval for medical cannabis use, and the state issued card, is contingent on reasonable adherence to the regimen given by my clinician. My card may be revoked at any time for inappropriate use as determined by my clinician or Inhale MD.
- I acknowledge that, per policy, all patients will have a limit of 2 ounces per 60 day period placed on the amount of cannabis that they can purchase. This is to protect patients from predatory sales tactics at dispensaries and to promote healthful use patterns.

ACKNOWLEDGEMENT OF CANCELATION POLICY

For all new patients we require payment prior to scheduling appointments. Payment is refundable, minus a $100 cancellation fee, up to 2 weeks prior to the appointment. After that, no refund will be issued. If you miss an appointment, or fail to reschedule an appointment prior to 2 business days before your appointment, you will be charged a $100 rescheduling deposit that will be refunded if no payment is due or applied to any payment due. If you are more that 10 minutes late for an appointment you may be asked to reschedule, subject to a $25 fee. This policy may be updated from time to time and you acknowledge that such changes as reflected on the Inhale MD website shall be final. It is up to you to remain informed of such policies.

AUTHORIZATION FOR RELEASE OF INFORMATION

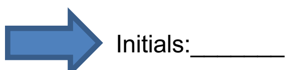
- I hereby authorize Inhale MD to disclose and verify my records as a patient to a cannabis dispensary for the purpose of obtaining cannabis. I understand that this authorization is valid for the period of time for which the recommendation for cannabis has been issued.
- I hereby authorize Inhale MD to disclose my medical records and recommendations to my other health care providers, without limitation, in accordance with general medical practice and HIPAA.
- I hereby authorize the use and disclosure of my patient records, except for personal identifying information, for use in data analysis of cannabis-treated patients
- I hereby authorize Inhale MD to disclose and verify to law enforcement my patient status should I be arrested or detained related to my possession or use of cannabis for the purpose of justifying my possession of cannabis. I understand that this authorization is valid for the period of time for which the recommendation for cannabis has been issued.

INFORMED CONSENT

I am being evaluated for a physician's certification that I meet the criteria set forth in Massachusetts State law for medical cannabis. The physician will make this certification based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use cannabis only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, growing of, sale/purchase and/or distribution of cannabis.

I have been informed of and understand the following: [please initial at the bottom of the page]

- I must be a Massachusetts resident to obtain an approval of recommendation for the use of cannabis.



Initials:_______

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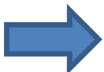
- The federal government has classified cannabis as a Schedule I controlled substance. Schedule 1 substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of cannabis even in medically legal states which have modified their state laws to treat cannabis as a medicine.
- cannabis has not been approved by the Food and Drug Administration for marketing as a drug. Therefore the "manufacture" of cannabis for medical use is not subject to any standards, quality control, or other oversight. Cannabis may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to Delta 9 THC, which is the primary psychoactive chemical component of cannabis.
- The use of cannabis can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using cannabis, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of cannabis, I can be arrested for "driving under the influence".
- Potential side effects from the use of cannabis include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short-term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Cannabis may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of cannabis may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment.
- I understand that using cannabis while under the influence of alcohol is prohibited by law. Additional side effects may become present when using both alcohol and cannabis.
- I agree to contact Inhale MD if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact Inhale MD if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends. If I cannot reach Inhale MD I will go to the nearest Emergency Room to seek treatment.
- Smoking cannabis may cause respiratory problems and harm, including bronchitis, emphysema and laryngitis. In the opinion of many researchers, cannabis smoke contains known carcinogens (chemicals that can cause cancer) and smoking cannabis may increase the risk of respiratory diseases and cancers in the lung, mouth and tongue. In addition, cannabis smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using cannabis, I will stop using it and report my symptoms to a physician.
- The risks, benefits and drug interactions of cannabis are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using cannabis and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).
- Individuals may develop a tolerance to, and/or dependence on, cannabis. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may
- be developing a dependency on cannabis, I should contact Inhale MD or seek treatment with my primary care MD or addiction medicine specialist.
- Psychological signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.
- Symptoms of cannabis overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to immediately go to the nearest emergency room.
- If Inhale MD subsequently learns that the information I have furnished is false or misleading, the recommendation for cannabis may no longer be valid and that the Cannabis Control Commission will receive notice of this fraudulent behavior. I agree to promptly meet with Inhale MD and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.
- I have had, or will have, the opportunity to discuss these matters with the clinician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. The clinician did inform me of the risks, complications of any recommended treatment.



Patient Signature:___________________________________

Date___________________