NATIONAL ACCESS CANNABIS

Family Physician Medical Documents Release

Patient Information

Date of Birth (mm/dd/yy): _____ /_____ /_____

First Name:_____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal Code:_____

Telephone:_____ Health Card#:_____

With the Condition:_____

Physician Information

Organization:_____

First Name:_____ Last Name: _____

Address:_____

City:_____ Province:_____ Postal Code:_____

Telephone:_____ Fax:_____

Release and Request for Medical Documents:

By signing below the Patient acknowledges that they have read, understood and agree that:

1. The Patient is a patient of the Physician.

2. The Physician has Medical Documents regarding the Condition and is requested to provide a copy of those documents, including prescriptions information, to National Access Cannabis using the fax number at the bottom of this form.

3. The Patient understands and acknowledges that medicinal cannabis is not currently approved for use as a pharmaceutical drug in Canada.

4. The Patient acknowledges and agrees that he or she may obtain medical cannabis as a result of requesting these medical documents and will do so at his or her own risk, and releases the Physician(and its partners, providers, officers, director and staff) from any and all actions, claims, complaints, and demands for damages, loss, or injury whatsoever arising directly or indirectly from the use of medicinal cannabis obtained through a Licensed Provider.

Patients's Signature:_____ Date:_____

Witness's Signature:_____ Date:_____

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