
Medical Deployment Services

2032 East Pleasant Valley Blvd
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Fax: (866) 329-3786

**Lawrence S. Levinson MD**

Diplomate American Board of Addiction
Certifying Physician for Medical Cannabis
www.MedicalDeployment.com
MD@MedicalDeployment.com

INSTRUCTIONS FOR RELEASE OF INFORMATION FORM
FOR MEDICAL CANNABIS CERTIFICATION

As part of the process to certify you for Medical Cannabis, it is essential for me to review your medical records before your appointment. This will ensure that you meet the requirements of having one or more of the 17 qualifying conditions.

The following page has a few areas for you to fill in

- Your name, address, birthdate and SS#
- The name of the physician who has the information we are requesting
- Your signature and the date signed

Once completed, please mail, fax or personally give this to your physician and ask that it be sent to me as soon as possible.

After I have received and your reviewed the records, I'll give you a call and confirm that we can proceed.

QUALIFYING CONDITIONS

Amyotrophic Lateral Sclerosis.
Autism.
Cancer.
Crohn's Disease.
Damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity.
Epilepsy.
Glaucoma.
HIV/ AIDS
Huntingtons disease.
Inflammatory Bowel Disease

Intractable Seizures.
Multiple Sclerosis.
Neuropathies.
Parkinson's Disease.
Post-traumatic Stress Disorder.
Severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain in which conventional therapeutic intervention and opiate therapy is contraindicated or ineffective.
Sickle Cell Anemia

Looking forward to meeting with you

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**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
SPECIFICALLY, FOR THE CERTIFICATION OF MEDICAL CANNABIS**

PATIENT NAME: _____

BIRTHDATE: _____

ADDRESS: _____

SS # _____

PHONE #: _____

I hereby authorize my doctor, _____ to release to Dr Lawrence S Levinson the following medical records, which may include psychiatric, drug and alcohol, and/or HIV information. The extent or nature of information to be released is for Certification for Medical Cannabis.

To provide this individual with certification by the Department of Health, I need the following supporting documents in order to confirm 1 or more qualifying condition(s).

- (X) Acute and Chronic Diagnoses
- (X) Medication list
- (X) Office progress notes from the last 2 years

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to the Medical Deployment Services. This consent will expire in one year from date signed, unless otherwise stated as follows: _____

I understand I may refuse sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected,

_____ Signature of patient	_____ Date signed	_____ Parent, guardian legal representative	_____ Date signed
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Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act.

A copy of this authorization has been () accepted () rejected by the patient/representative

FAX 866 329-3786
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BE ADVISED

This information is legally privileged and is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosure to any other party unless required by to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the content of these documents is strictly prohibited. If you have received this information in error, please notify Medical Deployment Services by calling 814 312-2213