Medical Deployment Services
2775 East Pleasant Valley Blvd
Suite 1 Altoona, Pa 16601
Phone (814) 201-2305
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, I am required to review your medical records before the appointment. This will ensure that you meet one or more of the many qualifying conditions.

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

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

Once completed, please Email, mail, fax or personally give this to your physician and ask that the requested information 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
Anxiety
Cancer
Crohns Disease
Chronic spasticity
Epilepsy
Glaucoma
HIV/AIDS
Huntington's Disease
Inflammatory Bowel Disease
Intractable Seizures
Multiple Sclerosis
Neuropathies
Parkinson's Disease
PTSD
Severe and Chronic Pain
Opioid Use Disorder
Sickle Cell Anemia
Terminal illness
Tourette syndrome

Looking forward to meeting you. Call me if you have any questions. 814 312-2213

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

PATIENT NAME: _____ DOB: _____

ADDRESS:_____ 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 document(s) in order to confirm 1 or more qualifying conditions.

(X) Acute and Chronic Diagnoses

(X) Medication list

(X) Office progress notes from this individuals last office visit

I understand this consent is vo1untary 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

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

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