ATHENA
CERTIFICATION
CENTER OF LANSING

PHYSICIAN STATEMENT

Certification of Medical Need for Use of Marihuana

I _____ certify I was evaluated for one or more medical conditions in reference to his/her need for medicinal (cannabis), qualifying with valid diagnosis for the use of Michigan Law. It is in Athena Certification Center(s) professional opinion that the above named patient may benefit from the use of medicinal Marijuana by state of Michigan Law. I have discussed the potential risks and contradictions of marijuana by the state of Michigan Law. I have informed my patient not to drive motor vehicles, operate watercraft , aircraft , heavy machinery or engage in any activity that requires alertness while using medicinal marihuana.

This is my medical certification of need for medicinal marihuana and is not a formal prescription for marihuana. It is statement of my professional medical opinion. This opinion is rendered as a consultant in expertise in General Medicine and not in the capacity of his/ her primary care provider. I repeat that this recommendation is in no way to be interpreted as a prescription as defined under federal law. It is a recommendation that adopts the legal provisions of Health and Safety Coded and is only meant to be used or applied under Michigan Law. Under Federal cannabis is a scheduled drug. Under Federal Law the sale possession and cultivation of marihuana illegal.

239 W Main St
Morenci, MI

Call Us:
517-214-9395

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PHYSICIAN STATEMENT

INITIAL

____ I declare under penalty of perjury and fraud that all information provided today is true and correct.

____ I declared under penalty of perjury and fraud that all statements made today are calculated and may be used and reliable assertions in revealing my authentic medical condition(s).

____ I declare under penalty of perjury and fraud that all my assertions can be relied upon as being true and correct.

____ I agree to hold harmless the doctor signing my physician certification along with any support person(s) if any of the above mentioned or paperwork (if any) is not genuine.

Time period covered: 24 Month(s)

I have read and understood the above physicians statement. I have been informed of the privacy it was (HIPPA) and of the penalties under Michigan Law for misrepresentation of fraudulence in presenting myself and my medical records for examining physician. I have been advised on the safe and prudent use of medicinal marihuana (cannabis).

Patient Name (print): _____

Patient Signature : _____

Date: _____

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RISK AND BENEFIT STATEMENT/ MEDICAL HISTORY

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RISKS AND BENEFITS

** **EFFECTIVE APRIL 1,2013**** The Michigan department of licensing and regulatory Affairs requires the physician to provide follow-up care, as stated in **PUBLIC ACT 512**, *"[the physician] has a reasonable expectation that he or she will provide follow-up care to the patient to monitor the efficiency of the use of medical marihuana as a treatment of the patients debilitating medical condition"*

MEDICAL HISTORY

FOR YOUR BENEFIT & OURS

Full Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Email: _____

DOB: _____

Age:_____

Drivers License #: _____

Marital Status? (Circle)

SINGLE / MARRIED / DIVORCED / WIDOWED / PARTNER / OTHER

Occupation:

What is your household income?_____

What is your highest level of education?_____

Primary Care Physician / Family Doctor:

Current Prescription/Non-Prescription Drugs:

Pregnant (circle): **Y** / **N**

Nursing (circle): **Y** / **N**

Cigarette smoker (circle): **Y** / **N**

How many each day?: _____

Please list any family Illnesses: _____

_____

_____

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MEDICAL HISTORY FORM

Indicate Qualifying Condition(s) for State Registry below (Circle all that apply)

CANCER / SEIZURES / CACHEXIA OF WASTING SYNDROME / HIV+AIDS / PTSD / AGITATION OF ALZHEIMER'S DISEASE / HEPATITIS C / CHRONIC PAIN / AMYOTROPHIC LATERAL SCLEROSIS / SPASMS / CROHN'S DISEASE / SEVERE AND PERSISTENT MUSCLE SPASMS / GLAUCOMA / NAIL PATELLA

FOR YOUR BENEFIT & OURS

Health Issues (Circle all that apply)

LUNGS / STOMACH / STOMACH / SKIN RASH / HEART / ANESTHESIA / BLOOD CLOTS / HEADACHES / BLOOD PRESSURE KIDNEYS / BLOOD TRANSFUSIONS / DIZZINESS / DIABETES / URINARY TRACT / SPECIAL DIET / FAINTING / ARTHRITIS / CONSTIPATION / HEARTBURN / LOSS OF VISION / VOMITING / BLOOD IN URINE / NUMBNESS / DEPRESSION / SLEEP DISTURBANCES / DIARRHEA / JOINT SWELLING / ABDOMINAL PAIN / LOSS OF FORCE OF STREAM / RINGING IN EAR / NOSE BLEEDS / TOOTH ABSCESS / HEAT (OR) COLD TOLERANCE / COLON / ORGAN TRANSPLANT / EYES / CHANGE IN STOOL COLOR

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MEDICAL MARIJUANA EVALUATION INTAKE FORM

EVALUATION INTAKE FORM

FOR YOUR BENEFIT & OURS

When did this problem/condition begin?

_____

Last time you visited the doctor about this condition:

_____

Treatments you have tried/trying for this condition:

_____

_____

Current Medications:

_____

_____

Previous, related surgeries:

_____

_____

Pregnant (circle):

Y / N / UNSURE

Do you plan to become pregnant in the next [2] years?

Y / N / UNSURE

Would you like us to send a copy of your visit note your PCP or other care provider?

Y / N / UNSURE

If yes, provider's name? _____

Will you be your own caregiver?

Y / N / UNSURE

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PATIENT ACKNOWLEDG-MENT - RELEASE OF LIABILITY

PATIENT ACKNOWLEDGEMENT & RELEASE OF LIABILTY

THE UNDERSIGNED ACKNOWLEDGES, AGREES THAT:

The risks from the use of marijuana for medicinal and recreational purposes and that these risks can be significant, including the potential for serious health problems and death, and while there may be benefits from the use of marijuana and/or therapeutic purposes, the risk(s) does exist and,

I knowingly and freely assume all such risks, both known and unknown, and assume full responsibility for my participation in the Michigan Medical Marijuana Program; and,

Athena physician(s) are not providing me with a "prescription" for medicinal marijuana, nor are they encouraging my use o marijuana for medicinal and recreational purposes. I understand that my Athena Physician(s) has not provided certification of my "qualifying: medical condition as required by the Michigan Medical Marijuana Act; and,

I have been avised by Athena of the risks and benefits of medicinal use of marijuana, and have received a copy of Athena "Risks & Benefits Statement," which clearly and succinctly lists both risks and benefits of the use of marijuana for medicinal purposes; including the warning and recommendation for use.

I, myself nd on behalf of my heirs, assigns personal representatives and next of employees, other participants, sponsoring agencies, sponsors, advertisers, with respect to all and any injury, disability, death, or loss of damage to person or property, now and forever, resulting from my use of medical marijuana.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERM, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Signed: _____

Date: _____

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MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

Purpose of request: I request an authorize the disclosure or release of my protected health information (as identified below) to the following provider:

Entity Requesting Information:
The Patient Information is being requested by:
Practice: My Marijuana Cards
Address: 239 W Main St.
City, State, Zip: Morenci, MI, 49256
Phone: (517)214-9395
Fax: (419)237-7118

Entity Providing Information:
Practice: _____
Provider: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

Patient Information:

_____ _____
Patient Name Date of Birth

_____
Address

_____
City, State, Zip

Description of information to be disclosed- I authorize the disclosure of the following protected health information about to the provider identified above (check one of the following):

☐ Complete Medical Record: or ☐ The following limited information (provide description)

_____

_____
Patient Signature Date

Copies of signed Authorizations are available upon request