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 the valid diagnosis for the use of Marihuana products under Ohio Law. It is in Athena Certification Center(s) professional opinion that the above named patient may benefit from the use of medicinal Marihuana by state of Ohio Law. I have discussed the potential risks and benefits of marijuana by the state of Ohio 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 a 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 a recommendation and 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 Code and is only meant to be used or applied under Ohio Law. Under Federal Law cannabis is a schedule 1 drug. Under Federal Law the sale, possession, and cultivation of marihuana is illegal.

ATHENA
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108 W Main St
Fayette, OH

Call Us:
419-237-7119

PHYSICIAN STATEMENT

** **EFFECTIVE SEPTEMBER 8, 2016****, in accordance with House Bill No.523, the use of medical marijuana will be authorized for Ohio patients with qualifying conditions. Ohio will also form the Medical Marijuana Control Program.

108 W Main St
Fayette, OH

Call Us:
419-214-9395

INITIAL

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

____ I declare 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: 365 day(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 Ohio Law for misrepresentation of fraudulence in presenting myself and my medical records for an examining physician. I have been advised on the safe and prudent use of medicinal marihuana (cannabis).

Patient Name (print): ______________________________

Patient Signature : ________________________________

Date: _________

CERTIFICATION
CENTER OF LANSING

RISK AND BENEFIT STATEMENT/ MEDICAL HISTORY

108 W Main St
Fayette, OH

Call Us:
419-214-9395

MEDICAL HISTORY

FOR OUR 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: ______________________________
____
____

MEDICAL HISTORY

FOR OUR BENEFIT & OURS

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

MEDICAL MARIJUANA EVALUATION INTAKE FORM

MEDICAL HISTORY

FOR OUR 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

EVALUATION INTAKE FORM

FOR OUR 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:

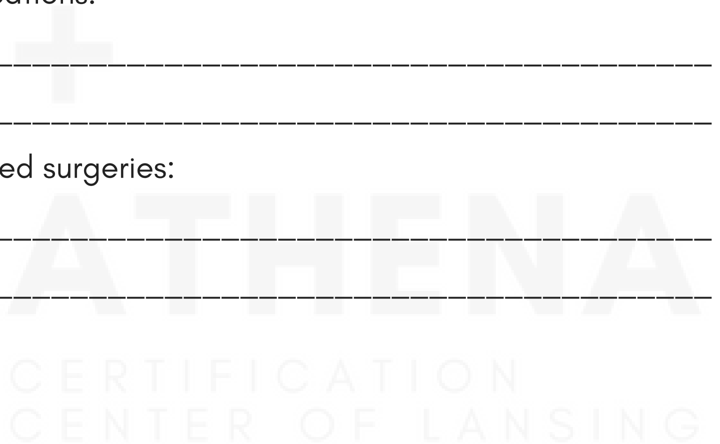
____

____

Previous, related surgeries:

____

____



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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 marihuana 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 marihuana 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 Ohio Medical Marijuana Control Program; and,

Athena physician(s) are not providing me with a "prescription" for medicinal marihuana, nor are they encouraging my use of marihuana for medicinal and recreational purposes. I understand that my Athena Physician(s) have provided certification of my "qualifying: medical condition as required by the Ohio House Bill No.523; and,

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

I, myself and 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 marihuana.

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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ATHENA CERTIFICATION CENTER OF LANSING

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: 108 W Main St.
City, State, Zip: Fayette, OH, 43521
Phone: (419) 237- 7119
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