

+

+

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 Marijuana by state of Ohio Law. I have discussed the potential risks and contradictions 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 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 Ohio Law. Under Federal cannabis is a scheduled drug. Under Federal Law the sale possession and cultivation of marihuana illegal.

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 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: 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 examining physician. I have been advised on the safe and prudent use of medicinal marijuana (cannabis).

Patient Name (print): _____

Patient Signature : _____

Date: _____





RISK AND BENEFIT STATEMENT / MEDICAL HISTORY

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

108 W Main St
Fayette, OH

Call Us:
419-214-9395



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:

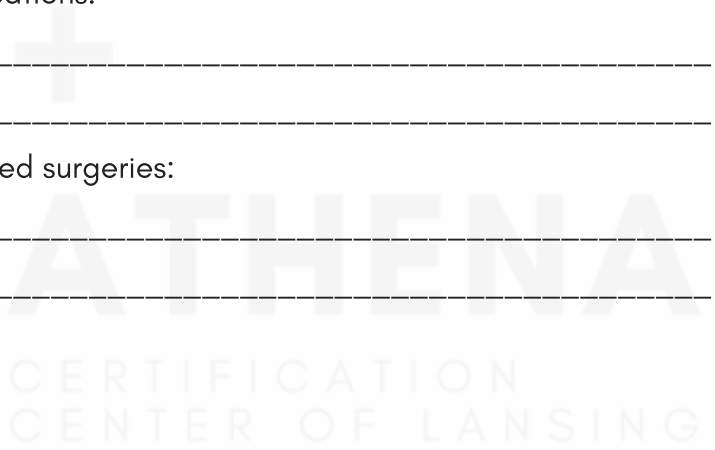
Treatments you have tried/trying for this condition:

Current Medications:

Previous, related surgeries:

108 W Main St Fayette, OH

Call Us: 419-214-9395





PATIENT
ACKNOWLEDG
-MENT
-
RELEASE OF
LIABILITY

**PATIENT ACKNOWLEDGEMENT & RELEASE OF
LIABILITY**

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 Ohio Medical Marijuana Control Program; and,

Athena physician(s) are not providing me with a "prescription" for medicinal marijuana, nor are they encouraging my use of marijuana for medicinal and recreational purposes. I understand that my Athena Physician(s) has 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 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 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 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.

108 W Main St
Fayette, OH

Call Us:
419-214-9395

Signed: _____

Date: _____



MyMarijuana
cards.com

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: Lansing, MI, 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