CONSENT TO TREATMENT

I hereby authorize CannaMD, its physicians, and staff (hereby referred to as the “Practice”) to examine and evaluate my medical condition(s). Based on its findings, the Practice will:

- Determine whether I qualify to be certified for the use of low-THC and/or medical cannabis per state regulations, place my order for low-THC and/or medical cannabis if I do qualify, and add, access, and update my record in the Medical Marijuana Use Registry.
- Examine and evaluate me for treatment going forward. (I understand I may be expected to provide urine for testing by a licensed clinical laboratory or by the Practice. I hereby authorize the Practice to collect and submit specimens for required testing and access results on my behalf.)
- Explain available remedies and treatments indicated by the results of my examination.
- Outline the significant risks and dangers associated with each remedy and treatment including, but not limited to, the potential benefits and risks of using low-THC cannabis and/or medical cannabis.
- Explain alternative medical solutions to each remedy and treatment, if acceptable alternatives exist.

As a patient of the Practice, I further acknowledge that:

- There is very limited scientific data available regarding the potential danger(s) of long-term low-THC cannabis and medical cannabis use.
- There are no guarantees regarding the benefits I may or may not experience from using low-THC cannabis and/or medical cannabis.
- The possession and use of low-THC cannabis and/or medical cannabis violates federal law.

I have read this *Consent to Treatment* and understand I will have the opportunity to have all of my questions answered by the Practice with respect to the treatments and therapies referred to above. I fully understand and acknowledge receipt of this form; I am signing it voluntarily.

Print Name: ____________________________________

Signature: ______________________________________ Date: _________________