MEDICAL RECORD RELEASE

Upon signing this document, I hereby authorize the release of confidential medical records to the entity listed below (including its physicians and employees).

Patient Name: _____ Date of Birth: _____

Please release my most recent progress note(s), identifying all current/active diagnoses. I understand that the information in my confidential health records may include information relating to sexually transmitted diseases (AIDS/HIV), behavioral or mental health services and treatment of alcohol abuse.

I hereby authorize (person or facility that has information):

Name: _____

Address: _____

Phone: _____

Fax: _____

To release to:

CannaMD Florida LLC.
7932 W. Sand Lake Rd. #205, Orlando, FL 32819
Phone: 1 (855) 420-9170 | Fax: 1 (800) 877-1589
NPI: 1356366884

The purpose or reason for this release of medical records is at the request of the undersigned patient. Without express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure.

_____ _____
(Patient Signature) (Date)

IF APPLICABLE, LEGAL REPRESENTATIVE SIGN BELOW:

By signing this form, I represent that I am the legal representative of the patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Legal Representative Name: _____

_____ _____