Disclosures and Conditions

Based on my belief and general information that I have obtained from different sources, which includes researching scientific literature about the established benefits and risks of using cannabis to treat my medical problems. I request the doctor to EVALUATE me for a possible recommendation for medicinal use of marijuana which would enable me to legally obtain cannabis.

Patients Initials: _____

I have been notified by this office and agree that if the use of cannabis ADVERSLY affects my health, I will stop using cannabis and will schedule an appointment to be further evaluated by a physician to determine another form of treatment for relief of my health problems. I assume all risks for usage.

Patients Initials: _____

I agree to provide the physician with all copies of my MEDICAL RECORDS, if they exist that document my medical conditions, as requested by the physician.

Patients Initials: _____

I agree to obtain medical FOLLOW-UP at my personal medical doctor's office or obtain a personal doctor if I have none now and return to this office for FOLLOW-UP, as recommended by the physician. I understand this is an obligation on MY part for the continuity of care.

Patients Initials: _____

I understand that SIDE EFFECTS associated with medical marijuana use include: dry mouth, nausea, headache, tremor, nystagmus, rapid heart rate, reduced muscle strength, decreased brain blood flow, decreased coordination, lung irritation, increased weigh gain, altered body temperature, anxiety, paranoia, confusion, aggressiveness, hallucinations, suicidal thoughts, sedation, altered libido, altered perceptions, addictive behavior, reduced testicular size and testosterone, menstrual abnormalities, infertility, abnormal ova, feta exposure in pregnancy.

Patients Initials: _____

I agree NOT TO DRIVE a car or operate dangerous or heavy machinery while using marijuana.

Patients Initials: _____

I DO NOT plan or intend to use my physician's recommendations for the purpose of illegally obtaining medical cannabis.

I AM NOT CURRENTLY ON PROBATION OR PAROLE. I UNDERSTAND THAT IF I AM ON PROBATION OR PAROLE AND DO NOT DISCLOSE TO THE DOCTOR, THEN MY RECOMMENDATION MAY BE REVOKED AT ANY TIME. I ALSO UNDERSTAND THAT WHILE ON PROBATION/PAROLE, ALL STATE AND FEDERAL LAWS SUPERSEDES MY MEDICAL RECOMMENDATION. IF MARIJUANA POSSESSION OR USAGE VIOLATES CONDITIONS OF PAROLE/PROBATION, THEN MY RECOMMENDATION MAY BE REVOKED AT ANY TIME.

I affirm that I have a serious medical condition that adversely affects my quality of life.

I have found or am interested in determining whether cannabis (i.e., Medical Marijuana) provides substantial relief and improvement of my condition.

I have discussed and have been informed by the medical practitioner of the potential benefits and risks of using cannabis.

I have been assured that medical records relating to my care will be kept private and confidential and that no information will be released or printed, which would disclose my personal identity, unless required by law.

I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations (FDA) concerning the safety and effectiveness of the medical use of marijuana as a drug, I understand the significance of this fact.

Amendment 2, Article X, Section 29 of the Florida Constitution and 381.986 Florida statute provides for the possession (Medical Marijuana) for the personal medical use. This clears the physician, staff and representatives of Green Balance Health and Wellness and are not providing cannabis, nor are they encouraging any illegal activity in my obtaining or using cannabis (medical marijuana).

I have read, understand and affirm all the above statements. Patient Signature: _____