MEDICAL CANNABIS TREATMENT CENTER OF HOLLYWOOD

MEDICAL RECORDS RELEASE

Patient Name_______________________________ DOB __________________

I REQUEST AND AUTHORIZE: ____

(Physicians Name)

Office Phone _______________________ Office Fax _________________________

To release healthcare information of the patient named above to:

The Medical Cannabis Treatment Center of Hollywood.

Please Fax to: (954) 272-0676

Or

E-mail to: mctc@browardspine.com

Or

Mail to: 3702 Washington Street Suite 407B Hollywood, FL 33021

I understand that I have the right to revoke this authorization at any time. My revocation must be in writing directly to The Medical Cannabis Treatment Center of Hollywood. I agree that a copy of this release or fax of this release shall be as valid as the original release. If I authorize faxing of any information, I realize there are inherent risks in faxing Protected Health Information released to anyone other than the health care provider.

Patient Signature ______________________ Date ___________________