DR WALKER WELLNESS

PATIENT RELEASE AND ACKNOWLEGMENT

I (Pt. name) _____

Living at (address) _____

City _____ State _____ Zip Code_____

I Understand and acknowledge:

(Initial each item below)

_____ The purpose of my visit to Dr. C Walker Wellness is for consultation and evaluation by a DPH registered and certified physician to determine if I medically qualify for an MMJ (Medical Marijuana) card that is issued by the Massachusetts Dept. of Public Health (DPH) for the medical use of marijuana pursuant to Massachusetts laws and regulations. Also I believe my medical condition(s) are chronic and debilitating and significantly effect and decrease my daily activities and quality of life.

_____ The Dr. C Walker Wellness physician(s), staff, agents and/or representatives are not providing, dispensing or encouraging me to obtain or secure MMJ, nor providing information regarding dispensaries, treatment centers or any other methods of obtaining or securing MMJ.

_____ The Dr. C Walker Wellness physician(s) and or staff are addressing only specific aspects of my medical care and conditions as consultation, and unless otherwise stated in writing, are in no way whatsoever establishing themselves as primary care, specialty care or health care providers to me. I have received, reviewed, understand and acknowledge the "MMJ Risks and Benefits" information given to me. I do not and will not hold Dr. C Walker Wellness physicians, staff, agents and/or representatives responsible or liable in any way whatsoever for my use of MMJ and any of its affects or side effects, or for any harm resulting to me or others as a result of my MMJ use.

_____ I acknowledge that Dr. C Walker Wellness has informed me that, and I am aware that, MMJ is an alternative to many recommended treatments for many conditions. I am aware of the potential side effects and risks of short and long term use of MMJ. I also agree to follow up with Dr. C Walker in 1-3 months as needed in regards to my MMJ treatment.

_____ I understand that MMJ is self-medication and further agree that if I elect to use MMJ I will use it strictly for the treatment of my authorized medical condition(s) and it will be at my sole discretion. I also agree to immediately cease using MMJ if I experience any side effects or ill effects from MMJ use and will contact my PCP and Dr. C Walker Wellness as soon as possible. I will also stop MMJ use if at any time I experience any severe side effect or ill effects including but not limited to, respiratory (breathing) problems, chest pain or any heart problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from family or friends or have thoughts of harm to myself or others, and I will call 911 for immediate emergency care.

_____ I understand that using marijuana while under the influence of alcohol is not recommended under any circumstances. I shall under no circumstances drive a car or operate machinery while under the influence of MMJ.

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_____I acknowledge that I will not smoke/use MMJ within 1000 feet of a school or day care center. I shall primarily use MMJ in privacy.

_____ I am not on probation for, or have legal matters pending for a drug or marijuana related offence.

_____ I acknowledge that the certifying physician may utilize the Massachusetts Prescription Monitoring Program prior to issuance of the registration/Pin number.

_____ I acknowledge that I am not an on duty agent of law enforcement, for the local, state or federal government and or here for the purpose of investigation or entrapment. I acknowledge that I am not a member of the media, newspaper or press and that all communication is strictly confidential. I acknowledge that I am not recording, filming or photographing any portion of my visit with Dr. C Walker Wellness, nor do I possess any recording equipment. I understand Dr. C Walker Wellness does not approve such action.

_____ (Females only) I am not pregnant but if I become pregnant, I will discontinue use of any form of Marijuana as its continued use may be unsafe and detrimental to the fetus.

_____ I understand that once the certifying physician at Dr. C Walker Wellness issues a Registration/Pin number the final decision for the issuance of an MMJ card will rest with the DPH. When under treatment, influence or in possession of MMJ, the MMJ card issued to me will be on my person at all times.

_____ I understand that if I am certified for MMJ use due to my condition(s) I will be given a Registration/Pin number by the certifying Dr. C Walker Wellness physician, this should allow me the ability to obtain an MMJ card from the DPH at their discretion, I am also aware of and agree to the Dr. C Walker Wellness fee for this service. I also acknowledge that there is a registration/application fee to the DPH that I am responsible for and is needed to obtain an MMJ card. I understand that if I am unable to perform such registration by myself, Dr. C Walker Wellness, if possible, may be able to assist me with this registration process for an additional fee.

_____ I acknowledge that I should always consult with my PCP before starting any new medication or medical treatment. I acknowledge having received a medical records release form from Dr. C Walker Wellness, and agree to provide any and all records related to my chronic and debilitating condition(s) as soon as possible and as needed.

_____ I acknowledge that all the information, medical information and medical history of my chronic and debilitating condition(s) that I have given, discussed or written down at Dr. C Walker Wellness is true to the best of my knowledge. Furthermore, if Dr. C Walker Wellness subsequently learns that any of the information I have furnished is false or misleading the registration with the DPH for an MMJ card may no longer be valid and I agree to promptly contact Dr. C Walker Wellness and provide additional accurate information.

_____ I understand that no confidential information will be released by Dr. C Walker Wellness without my consent unless required by HIPPA or due process of law, government or licensed authorities. I also authorize Dr. C Walker Wellness to verify my patient status to recognized legal authorities should I be detained by such authorities related to my possession or use of medical marijuana.

I agree with each of the statements above as evidenced by my initials and sign voluntarily.

Signature _____ Date _____