Five Points Wellness Center

Medical Records Statement

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

The Arizona Department of Health requires our physicians to review your medical records, 1) including medical records from other treating physicians you may have seen in the past twelve months, 2) note your response to conventional medications and medical therapies, and 3) review your profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program Database; before we can recommend medical marijuana or cannabis for your debilitating medical condition.

Please check one of the boxes below:

❑ I have not seen a physician within the past twelve months, so there are no medical records that exist from this time period. Any prescription(s) less than one year old that is recorded on the Arizona Prescription Monitoring Program Database are refills from an original doctor’s prescription(s) written more than a year ago.

❑ I have seen a physician within the past twelve months for which I have presented all my medical records that exist from this time period.

❑ I have seen other physician(s) within the past twelve months. I do not have a complete set of medical records with me at this time. I will request to have them sent to your office before my next visit, or I will bring them into the office with me during my next visit.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

(If patient is a minor - signature of parent/guardian)