•Laura Blevins, ND Crystal Yarnall, FNP •4036 S. 6th St. Ste.#2 Klamath Falls, OR 97603
•Phone: (541) 851-9320 •Fax: (541) 851-9322

INFORMED CONSENT AND RELEASE FROM LIABILITY

I am being evaluated for a medical provider's qualification for admission into the Oregon Medical Cannabis Program. The medical provider will make this qualification based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain a qualification and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use sale/purchase and/or distribution of marijuana.

I have been informed of and understand the following: [Initial each item]
____ Marijuana has not been approved by the FDA for marketing as a drug. Therefore the "manufacture" of marijuana for medical use is not subject to any standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.
____ The use of marijuana can affect coordination, motor skills, and cognition, such as the ability to think, judge, and reason. While using marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."
____ Potential **SIDE EFFECTS** from the use of marijuana include, but are not limited to, the following: Dizziness, anxiety, confusion, cough, bronchitis, lung problems, sedation, low blood pressure, impairment of short term memory, euphoria, nausea and vomiting (hyperemesis syndrome), difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and or/restlessness. Marijuana may exacerbate schizophrenia. In addition, the use of marijuana may increase eating, alter my perception of time and space and impair my judgement.
____ I understand that using marijuana while under the influence of alcohol, opioids/opiates, sedatives, or illicit drugs is not recommended. Additional side effects may become present when using both alcohol, opioids/opiates, sedatives, and illicit drugs with marijuana.
____ I agree to contact a medical provider or the emergency department if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact a medical provider or the emergency department if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.
____ The risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult

with my primary medical or mental health provider before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating medical provider.

____ Individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit I could be developing a dependency on marijuana and should seek medical assistance.
____ Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.
____ Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to go to the nearest emergency room.
____ If Wholesome Family Medicine subsequently learns that the information I have furnished is false or misleading, the qualification for marijuana may no longer be valid. I agree to promptly meet with Wholesome Family Medicine and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.
____I have had the opportunity to discuss these matters with the medical provider and to ask questions regarding anything I may not understand or that I believe needed to be clarified.

I acknowledge that the Wholesome Family Medicine provider informed me of the nature of the treatment of my medical condition, including but not limited to, voluntary treatment using medical marijuana. The provider also informed me of the risks, complications, expected benefits of medical cannabis, including its likelihood of success and failure. I acknowledge the medical provider informed me of any alternative treatment options including the alternative of no treatment, and the risks and benefits.

Furthermore, I, the undersigned (including my heirs, or anyone acting on my behalf), hold Wholesome Family Medicine LLC, the medical provider and his/her principals, agents, employees and management, harmless and release them from any liability resulting in any way whatsoever from my use of marijuana. This release of liability includes, but is not limited to, any bodily or psychological injury, whether known or unknown, as well as legal and/or employment problems resulting from my use of marijuana.

_____ _____
Patient Signature DATE

_____ _____
Printed Name Date of Birth