HIPAA Notice of Privacy Practices Acknowledgement of Receipt

By signing this, I hereby acknowledge that I have read and understood the privacy practice notice and may obtain additional copies upon my request. This acknowledgment will be filed with my records.

Authorization for Release of Confidential Records

I, _____, Date of Birth_____ hereby authorize Dr. Cannabus LLC. to disclose and verify me as a patient to any law enforcement agency, my Physician(s), Child Protective Services, or any state-approved Florida Dispensary. This is valid during the period for which the recommendation has been issued. This consent is subject to written revocation only, at any time I expect to the extent that action has already been taken based on this consent. I give my permission for my medical records and file to be reviewed by another physician working with Dr. Cannabus. I understand that this might happened if the original doctor that evaluated me needs a second opinion, is not available, off-premise has moved, or has terminated His/Her practice. I will as the doctor all questions regarding my treatment before the completion of my appointment

Patient Name: _____

Patient Signature: _____

Date: _____