hybridpharm

MEDICAL RECORDS RELEASE Form

318 Richmond Road – Ottawa, ON – K1Z 6X6
p: 613-695-4923 f: 343-888-2004 e: info@hybridpharm.com

PATIENT INFORMATION

First Name(s): _____ Last Name: _____

Birth Date: [M]_____ [D]_____ [Y]_____ Gender: ☐Male ☐Female ☐N/A

Health Card #: _____ *(Veterans please enter K#) Exp:* _____

Phone #: _____ Email: _____

Drug Allergies: ☐ NKDA
☐ Yes *(please specify)*: _____ _____
_____ _____

Medical condition(s): _____

HEALTH CARE PRACTITIONER INFORMATION

Organization: _____

First Name(s): _____ Last Name: _____

Address: _____ City: _____ Postal Code: _____ Province: _____

Phone #: _____ Fax #: _____ Email: _____

RELEASE AND REQUEST FOR MEDICAL DOCUMENTS

By signing below the patient acknowledges that they have read, understood and agree that:

1. The patient is a patient of the physician.

2. The physician has medical documents regarding the condition and is requested to provide a copy of those documents, including prescription information, to Hybrid Pharm, via fax, email or mail to the information provided in the header.

3. The patient understands and acknowledges that medicinal cannabis is not currently approved for use as a pharmaceutical drug in Canada.

4. The patient acknowledges and agrees that he or she may obtain medicinal cannabis as a result of requesting these medical documents and will do so at his or her own risk, and releases the physician (and its partners, providers, officers, directors and staff) from any and all actions, claims, complaints, and demands for damages, loss, or injury whatsoever arising directly or indirectly from the use of medicinal cannabis obtained through licensed provider.

SIGNATURES:

Patients signature : _____ **Date** (M/D/Y)**:** _____