

PATIENT DISCLAIMER & WAIVER OF LIABILITY

Medical Marijuana Evaluation Appointment

1. Purpose of Appointment

I understand that the purpose of this appointment is solely to determine whether I may have a qualifying medical condition under my state's medical marijuana laws.

I further understand that the healthcare professional does not guarantee approval for participation in the medical marijuana program.

2. No Medical Advice or Ongoing Care

I acknowledge and agree that:

The evaluating healthcare professional is not my primary care provider.

This evaluation does not establish a long-term physician-patient relationship beyond this assessment.

I am responsible for consulting my regular healthcare providers regarding my medical conditions and treatment options.

The healthcare professional is not providing medical advice, diagnosis, or treatment, except for determining eligibility for the medical marijuana program.

3. Risks of Medical Marijuana

I understand that:

Medical marijuana may involve risks, including but not limited to impairment, dizziness, memory or concentration issues, increased heart rate, dependency, drug interactions, and other known or unknown side effects.

Marijuana may impair my ability to drive, operate machinery, or perform tasks requiring alertness, and I agree not to engage in such activities while under the influence.

Medical marijuana products are not approved by the U.S. Food and Drug Administration (FDA), and scientific research regarding safety and effectiveness may be limited.

4. Compliance With State Law

I agree that:

It is my responsibility to review and comply with all applicable state laws regarding the possession, use, storage, and purchase of medical marijuana.

The healthcare professional bears no responsibility for my actions related to cannabis use after the evaluation.

Any recommendation, certification, or authorization provided is valid only within the applicable state and does not protect me from federal law enforcement, employment consequences, travel restrictions, or other legal issues.

5. Release & Waiver of Liability

By signing this document, I hereby fully release, waive, and discharge the healthcare professional and their organization from any and all liability, including but not limited to my use, misuse, or non-use of medical marijuana; any physical, psychological, or legal consequences arising from cannabis use; and any actions I take based on the outcome of the evaluation.

6. No Guarantee of Outcome

I understand that the evaluation may result in approval, denial, or a request for additional documentation.

Certification is not guaranteed. Fees paid for the evaluation are fully refundable if the healthcare professional is unable to certify my eligibility.

7. Truthfulness of Information

I certify that all information provided during this evaluation is true, complete, and accurate. Providing false or misleading information may result in denial of certification.

8. Patient Acknowledgment & Signature

I acknowledge that I have carefully read and fully understand this Disclaimer & Waiver. I have had the opportunity to ask questions. I voluntarily agree to these terms.

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

This Notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

Our Pledge Regarding Your Health Information

We understand that your medical information is personal and confidential. We are committed to protecting your health information. This Notice applies to all records of your care created or maintained by our practice.

How We May Use and Disclose Your Health Information

Treatment, Payment, and Healthcare Operations as permitted by law.

Other Uses and Disclosures Allowed or Required by Law include compliance with laws, public health activities, health oversight agencies, legal proceedings, law enforcement, coroners, organ donation, workers' compensation, and approved research.

Uses and Disclosures Requiring Authorization

Marketing, sale of medical information, psychotherapy notes, or any use not described in this Notice require written authorization.

Your Rights Regarding Your Health Information

You have rights to inspect, copy, amend, restrict, request confidential communication, request accounting of disclosures, and obtain a copy of this Notice.

Questions or Complaints

Email: inquiry@simplymedicalcards.com

You may also file a complaint with the U.S. Department of Health and Human Services. We will not retaliate.