COUNTY OF LOS ANGELES
DEPARTMENT OF PUBLIC HEALTH
MEDICAL MARIJUANA IDENTIFICATION CARD PROGRAM (MMIP)

GENERAL CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's Last Name	First Name	Middle Name	Birthdate
Street	City	Zip Code	Telephone #

I, the undersigned, hereby authorize: (Provider/Organization with the records)

Name		
Street Address		
City	State	Zip Code

To provide to:

County of Los Angeles Medical Marijuana Identification Card Program (MMIP)
241 N. Figueroa Street 1st Floor, Room 128, Los Angeles, CA 90012
Phone: (866) 621-2204 Fax: (213) 975-9651

Access to my medical records for the purpose of:

VERIFICATION OF THE MEDICAL MARIJUANA RECOMMENDATION

Restrictions:

I understand that this authorization is voluntary. Treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization. I understand that the physician or health care provider releasing my medial information and PHI (protected health information) pursuant to this request to the person designated on this form may not be held liable for the mis-use of such information when received by the person designated on this form.

I understand that the person designated on this form to receive my information may not further use or disclose my medical information or PHI (protected health information) unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Unless otherwise revoked in writing, this authorization expires in 3 months. You may revoke this authorization in writing at any time by sending a notice to the Medical Marijuana Identification Program.

_____ _____
SIGNATURE OF PATIENT/PARENT-LEGAL GUARDIAN/ PERSONAL REPRESENTATIVE (PLEASE CIRCLE) DATE

_____ _____
SIGNATURE OF WITNESS (DEPT OF PUBLIC HEALTH STAFF ONLY) DATE

REV 6/07