Release of Information Authorization

Eastern Shore MediCann Clinic, LLC
443-666-0711

Name:_____

Date of Birth:_____

Phone Number:_____

Last 4 Digits of SS#:_____

Records Requested from Dr._____

Phone #:_____

Fax #:_____

Information requested for continuum of care:

A letter printed on business letterhead containing:

Patients medical condition
Duration of medical condition
Failed Treatments
Date of last office visit

Please provide any relevant imaging, lab or pathology reports

By signing below I do hereby consent and authorize the release of my medical records to Eastern Shore MediCann Clinic, LLC:

Patient Signature:_____

Date:_____