Medicinal Cannabis Control Commission

CHAIR Lisa Brunner VICE CHAIR Regina Murray COMMISSIONER Marcy Hart

Health Care Practitioner Patient Certification Acknowledgment

MEDICINAL CANNABIS PATIENT REGISTRY PROGRAM

I am aware that my participation in the Medicinal Cannabis Patient Registry Program is voluntary. I certify that I am primarily responsible for the care and treatment of the patient's qualifying medical condition(s) I will certify, and that I am a Minnesota licensed Doctor of Medicine, a Minnesota licensed physician assistant acting within the scope of authorized practice, or a Minnesota licensed advanced practice registered nurse. I also certify that my licen

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Authorization For Use and Disclosure of Information

Name of Client: _____ Patient/Chart #: _____

Date of Birth: _____ Phone #: _____

I Authorize Name/Company:

_____

_____

_____

To release or exchange with:

W.E. Medicinal Cannabis Control Commission
779 E Jefferson Ave, Mahnomen MN 56557
Phone: 218-935-2148

Phone: _____ Fax: _____

Specific Dates of Information to be disclosed: From: _____ To: _____

☐ Diagnosis	☐ Admit/Discharge Dates & Reports	☐ Family Involvement Information
☐ Diagnostic Assessment	☐ Progress Reports	☐ School Reports/IEP
☐ Psychiatric Evaluation	☐ Medications	☐ Psychological Assessment and Testing Results
☐ Recommendations	☐ Substance Abuse Assessment	☐ Treatment Plans
☐ Verbal Only	☐ Verbal & Written upon request	☐ Other: (Specify) _____

The information is necessary for:	☐ Diagnosis & Treatment	☐ Coordination & Follow-Up
☐ Family Involvement	☐ Update Record	☐ Acknowledge Referral
☐ Insurance Purposes	☐ Education Purposes	☐ On-Site Chart Review
☐ Make Appointments	☐ Client Record	☐ Emergency Notification
☐ Medication Management	☐ Other (Specify): _____	

Please Note the Following:

1. You may refuse to sign this authorization. Your refusal will negate your participation in the White Earth Medicinal Cannabis Commission Patient Registry Program.
2. If the persons or entities authorized to receive the information are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws will no longer protect the disclosed health information.
3. I agree a photocopy or facsimile of this release be accepted with the same authority as the original.
4. This authorization will be effective for three (3) years or until you revoke it. You may revoke this authorization by delivering a dated and signed letter to our program.

Client Signature: _____ Date: _____

Client is unable to give consent because: _____ Parent/Guardian (Print): _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOTE: If the client is unable to sign, the person signing the authorization may be required to show proof of guardianship, or authority, and

se to practice medicine is unrestricted. I agree to notify the Medicinal Cannabis Control Commission (MCCC) if my license becomes restricted or revoked or if I decide to discontinue care for patients in the Medicinal Cannabis Patient Registry Program.

I have issued the patient a certification of my diagnosis that the patient suffers from a qualifying medical condition(s).

I acknowledge that, in certifying this patient's qualifying medical condition(s) for the Medicinal Cannabis Patient Registry Program, I have the primary responsibility for the care and treatment of the qualifying medical condition of this patient and have:

- Reviewed the patient's medical history to confirm the diagnosis within my professional standards of practice.
- Conducted an in-person evaluation of this patient sufficient to confirm this diagnosis; or, if the examination was conducted via telemedicine to recertify the patient's qualifying medical condition, I attest that the assessment complied with Medicinal Cannabis Control Regulations.

If this patient is enrolled in the Medicinal Cannabis Patient Registry Program, I will:

Continue treatment of the patient's qualifying medical condition(s) that conforms to acceptable and prevailing medical practice standards and report medical findings to Medicinal Cannabis Control Commission.

- Notify MCCC in the event of the death of this patient, by emailing Lisa.Brunner@whiteearth-nsn.gov within 14 calendar days of learning of the death; and
- Determine, every three years, if the patient continues to suffer from a qualifying medical condition(s) and, if so, issue the patient a new certificate of that diagnosis; and
- Comply with all requirements developed by Medicinal Cannabis Control Commission relating to the Medicinal Cannabis Patient Registry Program.

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Mahnomen, MN 56557
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Lisa.Brunner@whiteearth-nsn.gov