

PATIENT CONSENT

Individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact Show-Me Clinic.

Signs of withdrawal include feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness. Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to go to the nearest emergency room.

If Show-Me Clinic subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly meet with Show-Me Clinic and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Show-Me Clinic informed me of the nature of a recommended treatment, including but not limited to, recommendations regarding medical marijuana. The Show-Me Clinic physician also informed me of the risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge the Show-Me Clinic physician informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

Furthermore, I, the undersigned (including my heirs, or anyone acting on my behalf), hold Show-Me Clinic, the physician and his/her principals, agents, employees and management, harmless and release them from any liability resulting in any way whatsoever from my use of marijuana. This release of liability includes, but is not limited to, any bodily or psychological injury, whether known or unknown, as well as legal and/or employment problems resulting from my use of marijuana. The attending physician, staff and/or representatives of Show-Me Clinic are neither providing, dispensing nor encouraging me to obtain medical marijuana. The attending physician, staff and/or representatives of Show-Me Clinic will NOT be discussing information regarding dispensary, co-op, delivery service or any other way to obtain marijuana. The physician, staff and representatives of Show-Me Clinic are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician/provider.

Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the physician. It is my responsibility to see the physician to assess the possible continuance of cannabis use beyond the term of the approval.

I acknowledge that I am a resident of this state, I am at least 18 years of age, and have not misrepresented any information to Show-Me Clinic.

I acknowledge that I am not an agent of law enforcement, state or federal government or news media here for the purpose of investigation, reporting or entrapment.

I acknowledge that I am not recording any portion of my visit with Show-Me Clinic nor do I possess any recording equipment. I understand Show-Me Clinic does not approve of such action. I further acknowledge that, without express written permission from Show-Me Clinic, it is illegal to film or record in this office with a video camera, cell phone or any other recording devices, including still image, video or audio. Any such action is a direct violation of HIPAA regulations and patient/doctor confidentiality.

RECORD RELEASE CONSENT

I hereby authorize Show-Me Clinic to disclose, release and verify my records as a patient to a marijuana dispensary, caregiver or coop for the purpose of obtaining marijuana. I understand that this authorization

is valid for the period of time for which the recommendation for marijuana has been issued by my Show-Me Clinic physician.

I hereby authorize the use and disclosure of my Show-Me Clinic patient records, except for personal identifying information, for use in data analysis of cannabis treated patients.

I hereby authorize Show-Me Clinic to disclose and verify my medical records to law enforcement should I be arrested or detained related to my possession or use of marijuana. I understand that Show-Me Clinic will only provide verification of my patient status for the purpose of providing proof to justify my possession of marijuana. I understand that this authorization is valid for the period of time for which the recommendation for marijuana has been issued by my Show-Me Clinic physician.

I am being evaluated by a physician for qualifying condition for medical marijuana. The physician will certify the condition based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of marijuana.

I must be a resident of this State and over the age of 18 to obtain an approval or recommendation for the use of cannabis (medical marijuana) under State law. If I am under 18 years of age, I must have a parental consent and authorization for the use of medical marijuana.

The federal government has classified marijuana as a Schedule 1 controlled substance. Schedule 1 substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states which have modified their state laws to treat marijuana as a medicine.

Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore the "manufacture" of marijuana for medical use is not subject to any standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients (i.e., can vary in potency), impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and /or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence." I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana. I agree to contact my primary care physician if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact my primary care physician if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends. Smoking marijuana may cause respiratory problems and harm, including bronchitis, emphysema and laryngitis. In the opinion of many researchers, marijuana smoke contains known carcinogens (chemicals that can cause cancer) and smoking marijuana may increase the risk of respiratory diseases and cancers in the lung, mouth and tongue. In addition, marijuana smoke contains harmful chemicals known as tars. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician. The risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medications or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

HIPAA COMPLIANCE

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

POTENTIAL SIDE AFFECTS

Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short-term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skill, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in a person predisposed to this disorder. In addition, the use of marijuana may increase eating, alter perception of time and space, and may impair judgment.

I hereby confirm that all the above provided information is true. I also agree and hereby confirm that I understand the potential side effects of Medical Marijuana use.

I acknowledge that I have read and agree to the above terms and conditions.

☐ I consent to receive communications from the clinic by email, phone, and text.

Patient Name

Patient Signature

Date