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GREEN MD NOW
CANNABIS FOR VIBRANT LIFE

Medical Records Request Form

Patient Identification:

Patient's Legal Name: _____

Date of Birth: _____

Last 4 of SSN: _____

Address: _____

Phone Number: _____

Previous Provider Information:

I _____, authorize **Khaja Chisty, M.D.** to obtain my complete records from:

Previous Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing and/or other sensitive information, I agree to its release.

Check One: _____Yes _____No Please Initial _____

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check One: _____Yes _____No Please Initial _____

Signature: _____ **Date**: _____