

Patient Received By: _____

Physician Contacted By: _____

Verified Not Verified

Date: _____ Time: _____



Patients Information

Last Name: _____

Middle Name: _____

First Name: _____

Home Address: _____

City, State, Zip: _____

Date of Birth: ____/____/____ Phone: (____) ____ - ____

Email Address: _____

Prescribing Physician's Information

Physicians Name: _____

Address: _____

City, State, Zip: _____

Phone: (____) ____ - ____

Medical Release

I hereby authorize my treating physician, as required by State and Federal Laws including HIPAA regulations, to release my medical information concerning my diagnosis, condition, and/or recommendation to The Wellness Earth Energy Dispensary, Inc. and its duly authorized representatives.

Patients Signature: _____ Date: _____