



This is not an endorsement for Medical Marijuana.

Dear Doctor,

Your patient has consulted Greenleaf Care for review of their medical history/current medical condition to determine if medical marijuana may be helpful. Please complete the following and return to my office.

NAME OF PERSON/TITLE OR FACILITY WHICH HAS YOUR HEALTH INFORMATION _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: _____ FAX: _____

To release health information to: _____

(PERSON OR FACILITY TO RECEIVE HEALTH INFORMATION)

Greenleaf Care
MEDICAL RECORDS
3039 Jefferson Street, Suite F, Carlsbad CA, 92008
PHONE: 888.774.7076 | FAX: 619.291.7217

- Cancer type:
- HIV/AIDS:T-cell count
- Amotrophic Lateral sclerosis
- Glaucoma
- Hepatitis C: caused by:
- Cronos Disease
- Nail Patella
- Severe and Chronic Pain: caused by:
- Seizures type:
- A medical condition or its treatment that produces, for a specific patient, 1 or more of the following:
 - cachexia or wasting syndrome
 - severe and chronic pain
 - severe nausea
 - seizures, including but not limited to those characteristic of epilepsy
 - or severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis.
 - Explanation (optional) _____

Patient Signature: _____ Printed name of physician: _____

Date: _____