CANNABIS AUTHORIZATION CLINIC
11503 REISTERSTOWN RD
OWINGS MILLS MD 21117
(443) 800-2917
weedapprovals.com
support@weedapprovals.com

Dear Health Care Provider:

Re: (patient name):
(DOB):

Your patient is requesting authorization to
purchase and use medical marijuana. In order to provide this authorization, we will need documentation of the condition or conditions it is to be used for. This can be accomplished by either filling out this form or providing copies of the pertinent medical records. Thank you for your cooperation.

Alan Mitnick M.D.

Please check the conditions that apply to this patient:

_____Cachexia
_____Anorexia
_____Wasting Syndrome
_____Severe or Chronic Pain
_____Severe Nausea
_____Seizures
_____Severe or Persistent Muscle Spasms
_____Glaucoma
_____PTSD
_____Another Chronic Medical Condition
Which is Severe and Refractory to
Other Treatments

Please comment on the approximate duration, severity, and treatment for the pertinent conditions: (use back if necessary)

Health Care Providers Name (Printed): Signature:

_____ _____

Address:

_____

Phone:

_____