Release of Information Authorization

Tri State Cannabis, LLC
349 E. Pulaski Hwy
Elkton, MD 21921
P: 410 618 6315
F: 410 392 9981

NAME:______________________________________

Date of Birth:______________________________________

Phone Number:______________________________________

Last 4 Digits SS#:______________________________________

Records Requested from Dr.______________________________

Phone #:______________________________________

Fax #:______________________________________

Information requested for continuum of care:

- **-A letter printed on business letterhead containing:**
    - **-Patient's medical condition**
    - **-Duration of medical condition**
    - **-Failed Treatments**
    - **-Date of last office visit**

- **-Please also provide any relevant imaging, lab, or pathology reports**

I do hereby consent and authorize the release of my medical records to TSC,LLC.

Patient Signature:____________________________

Date:______________________________________