



## Release of Medical Information

I hereby authorize the release of any and all medical records pertaining to my care to:

Columbus Cannabis Consultants  
3600 Olentangy River Road  
Building 480  
Columbus, OH 43214  
Fax: 855-453-5002  
Phone: 614-442-0700

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Signature: \_\_\_\_\_

3600 OLENTANGY RIVER ROAD • SUITE 480 • COLUMBUS, OHIO 43214  
COLUMBUSCANNABISCONSULTANTS.COM

614-442-0700  
855-453-5002