Ohio Holistic Healthcare
570 North Leavitt Road
Amherst, OH 44001
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Consent To Treat with Medical Cannabis

I, _____, give my permission to Ohio Holistic Healthcare to evaluate _____ for a possible approved recommendation of cannabis for the treatment of the certified condition(s).

Patient Signature: _____

Date of Birth:_____ Date/Time:_____

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Parent/Legal Guardian Cannabis Consent Form:

I, _____, parent or legal guardian of _____, give my permission to Ohio Holistic Healthcare to evaluate my _____for a possible approved recommendation of cannabis for the treatment of his or her condition(s).

Signature of Parent or Legal Guardian: _____

Relationship to patient: _____ Date:_____

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OHHC Staff Witness:_____ Date:_____