

MEDICAL MARIJUANA HIPPA WAIVER HEALTH INFORMATION PRIVACY

I am aware of my right to privacy of my health related information. I hereby authorize the use and disclosure of the medical information contained in the medical recommendation of my physician for medical marijuana and confirmation with the doctor by the center, from time to time. I also understand a copy of my record will be kept by the center on file. I understand that the center's policy on privacy is to not disclose the name or identity of any patient other than in the course of confirmation of the recommendation. I understand that I may have extra protection under California and Federal law as to my information. However, I expressly authorize the use and storage of this information in accordance herewith. I understand I may revoke my authorization in writing at any time and that the center will then maintain a record, but block out my name. I understand I am under no obligation to sign this form; however I realize that in order to ask the center to provide me access to medical marijuana and at my own personal request for instance, I grant the right to is the information as described herein. I understand I have a right to inspect or copy this authorization, and my file with the center. I understand that there is the possibility of redisclosure of information in the course of confirming my recommendation. This authorization shall terminate on the termination of me medical recommendation unless terminated sooner in writing by me. I have had an opportunity to review this form, and I confirm it accurately reflects my wishes.

Signed

Date

Print Name

Signature of Parent or Guardian if patient is a minor or unable to sign