Dosecann Cannabis Program

For Client

Dosecann Cannabis Program
1-833-565-2278
clientcare@dosecann.com
55 Bruce Crescent
Ottawa, Ontario K7C 3T3
Monday – Friday
9:00 AM to 5:00 PM EST

CONSENT FORM A – TO DISCLOSE PERSONAL HEALTH INFORMATION

To be completed by applicant and given to your health care practitioner and the Dosecann Cannabis Program.

I, _____ **authorize** _____ **to disclose:**
(Applicant) **(Health Care Practitioner)**

Please select:

☐ **As the Applicant:** My personal health information consisting of: dosage information of cannabis used for medical purposes, to verify the health care practitioner's order as required by the Dosecann Cannabis Program.

☐ **As the Caregiver:** The personal health information of _____ consisting of: dosage information of cannabis used for medical purposes, to verify the health care practitioner's order as required by the Dosecann Cannabis Program

I understand the purpose of disclosing this personal health information to the Dosecann Cannabis Program.
I understand that I can refuse to sign this consent form.

Note: A substitute decision maker is a person authorized under applicable privacy legistlation to consent, on behalf of an individual, to disclose personal health information about the individual.

PERSONAL INFORMATION

First Name _____ Last Name _____
Street Address _____
City _____ Province Postal Code _____
Primary Phone _____ Email Address _____
Signature _____
Date _____

Please submit a copy of this form to the Dosecann Cannabis Program by email at clientcare@dosecann.com and also send a copy to your health care practitioner.