CHANGE OF INFORMATION FORM (page 1 of 2)

Mail/Fax to: Entourage Brands Corp.
P.O Box 69
Bowmanville, Ontario
L1C 3K8

T: 1-844-756-7333
S-Fax: 1-844-756-0470

info@starseed.com
www.starseed.com

Fill this out this form if you need to change any personal information such as changes to your name or address. All changes to personal information on file require a written request submitted to Entourage Brands Corp. If you need to change any of the information originally submitted in your Registration Application, please complete this Change of Information Form and send the signed document back to us by mail, fax, or email.

SECTION 1: Patient Information

This section is required. Information must match information on original patient registration form**:**

First Name: Last Name:

Client ID #:

Please provide only the information you wish to change below and include proof of changes made to your name, gender, date of birth and/or address with this document (i.e. image of photo ID):

First Name: Last Name:

Date of birth (MMM/DD/YYYY): Male: ☐ Female: ☐ Other: ☐

SECTION 2: Residence Address

Primary residence must be in Canada ☐ Use residence address as my shipping address

Address: Unit #: Province:

Address 2: City: Postal Code:

Type of Residence Address Private residence: ☐ Establishment: ☐

Type of Establishment (long term care facility, shelter, etc.): Name of establishment, if not private residence:

If manager from specified institution provides services to applicant, manager must also sign on page 2.

SECTION 3: Alternative Mailing Address

Alternative address must be in Canada ☐ Use alternative address as my shipping address

To be completed if: Residence address in Section 2 is different from mailing and/or shipping address or if the applicant does not have a permanent address. If the manager from a specified institution provides services to the applicant, the manager must also sign on page 2.

Address: Unit #: Province:

Address 2: City: Postal Code:

Type of Alternative Address Private residence: ☐ Establishment: ☐

Type of establishment (long term care facility, shelter, etc.): Name of establishment, if not private residence:

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SECTION 4: Health Care Practitioner Information

If the health care practitioner who provided the medical document has agreed to receive cannabis products on behalf of the applicant, please complete this section.

☐ Use health care practitioner address as shipping address

First Name: Last Name:

Address:

Address 2: City:

Province: Postal Code: Phone #: Email / Fax # (if applicable):

I hereby consent to receive cannabis on behalf of the patient listed on page 1.

Health care practitioner signature:

Date Signed (MMM/DD/YYYY):

SECTION 5: Authorization

As applicant or a responsible individual you acknowledge, attest, agree and consent to the following:

(i) the applicant ordinarily resides in Canada;
(ii) the information in the application is correct and complete;
(iii) the medical document that forms the basis for the application has not, to the knowledge of the individual signing the statement, been altered;
(iv) the medical document is not being used to seek or obtain cannabis products from another source;
(v) the applicant acknowledges that Entourage Brands Corp, in its sole discretion, may limit products purchased in accordance with its Commercial Policy. Entourage Brands Corp. may require patients to request an Exception Use Letter from their healthcare practitioner should they require dosages above the limits outlined in the Commercial Policy. Entourage Brands Corp. may from time to time, update its Commercial Policy;
(vi) in the case where the applicant is signing the statement, they intend to use any cannabis product that is supplied to them on the basis of the application only for their own medical purposes;
(vii) in the case where an adult who is responsible for the applicant is signing the statement, they are responsible for the applicant; and
(viii) I authorize Entourage Brands Corp. and my healthcare practitioner to disclose my personal health information consisting of: order history and dose information of cannabis used for medical purposes, as a verification of the healthcare practitioner's orders, as required and on a continuous basis. I have been informed of how my personal health information will be used and understand the purpose for disclosing my personal health information noted above. I understand that I can refuse to sign this consent, and consent may be withdrawn or amended at any time.

Applicant Signature:

Date Signed (MMM/DD/YYYY):

To be completed by a manager of the specified institution that provides services to the applicant:

I, _____ (Manager's Name) , confirm that _____ (Establishment Name)

provides food, lodging or other social services to _____ (Applicant's Name)

Manager's Signature:

Date Signed (MMM/DD/YYYY):

Please indicate if you are the applicant or a caregiver who is responsible for the applicant:

Applicant: ☐ Caregiver: ☐ Other Responsible Individual: ☐