STARSEED
Medicinal Inc.

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Consent To Disclose Personal Health Information

Patient Name _____ _____
Last Name First Name

Date of Birth _____ **Gender** ◯ Male ◯ Female ◯ Other
MMM / DD / YYYY

Address _____

City _____ **Province** _____ **Postal Code** _____

Telephone _____ **Health Card #** _____

I, _____ , authorize _____ to disclose:
Print Your Name Print name of health care practitioner

◯ My personal health information consisting of: Dose information of cannabis used for medical purposes, as a verification of the health care practitioner's orders, as required.

or

◯ The personal health information *of:* _____
Name of person for whom you are the substitute decision-maker

consisting of: Dose information of cannabis used for medical purposes, as a verification of the health care practitioner's orders, as required.

To: STARSEED MEDICINAL INC.

The disclosure may take place: (check one) ◯ on a continuous basis ◯ at particular intervals if so: _____ ◯ only once
Specify Interval

I have been informed of how my personal health information will be used and understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form and that this consent may be withdrawn or amended at any time.

My Name _____ **Signature** _____ **Date** _____

Witness Name _____ **Signature** _____ **Date** _____

Address _____ **Home Phone** _____ **Work Phone** _____