CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

To be completed by applicant and given to health care practitioner and Kolab Project.

I, _____ **authorize** KOLAB PROJECT INC. **to disclose:**
(Your Name) (Name of Health Information Custodian)

Please Select:

☐ My personal health information consisting of: dosage information of cannabis used for medical purposes, as a verification of the health care practitioner's order as required by Kolab Project Inc.

☐ The personal health information of _____ consisting of:
(Name of person for whom you are the substitute decision maker)

dosage information of cannabis used for medical purposes, as a verification of the health care practitioner's order as required by Kolab Project Inc.

I understand the purpose for disclosing this personal health information to Kolab Project. I understand that I can refuse to sign this consent form.

Note: A substitute decision maker is a person authorized under HIPA 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 Please Select

Postal Code _____ PO Box _____

Primary Phone _____ Email Address _____

Signature _____

Date _____