SpectrumTherapeutics™

Veterans Affairs Canada Consent to Disclose

To arrange direct billing, Veterans Affairs Canada requires Spectrum Therapeutics to provide information, for which we need your permission.

I, _____ (Full Name) authorize Spectrum Therapeutics to disclose to Veterans Affairs Canada.

Please select one of the following two options:

Check option 1 if you are completing this form for yourself.
Check option 2 if you are an individual responsible for the applicant for the person obtaining medical cannabis.

◯ **1)** My personal health information consisting of dose information of cannabis used for medical purposes, the specific condition for which medical cannabis is being used, and any additional information required to validate my eligibility for coverage.

◯ **2)** The personal health information of _____ (Applicant Name) consisting of dose information of cannabis used for medical purposes, the specific condition for which medical cannabis is being used, and any additional information required to validate my eligibility for coverage.

If you selected option 2 above, please read and check the following as well.

☐ I represent and warrant that I meet all of the requirements to be _____ (Applicant Name)'s substitute decision-maker under the applicable legislation.

☐ *I understand the purpose of disclosing this personal health information to Veterans Affairs Canada.*

☐ *I understand that I can refuse to sign this consent form.*

Your information

Signature _____ Name _____ (Printed)

Telephone _____ Email _____

Fax _____

For More Information
1-855-558-9333
Care@SpectrumTherapeutics.com
SpectrumTherapeutics.com

Secure ePortal Fax Line
1-888-977-2595

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