

## **Veterans Affairs Canada Consent to Disclose**

I,	(Full Name)	author	rize Spectrum Therapeutics to discl	ose to Veterans
Affairs Canada.				
Please select one	e of the following two options:			
	rou are completing this form for y rou are an individual responsible i		erson obtaining medical cannabis.	
condition f	or which medical cannabis is bei ge.	ng used, and any addition	nnabis used for medical purposes, t al information required to validate r	ny eligibility
<b>2)</b> The persor of cannabis	nal health information of	(Applicant Name specific condition for whi	consisting of doscich medical cannabis is being used,	e information and any
	nformation required to validate m	•	<b>3</b> ,	•
additional i	nformation required to validate motion 2 above, please read an	ny eligibility for coverage.  d check the following a	s well.	ŕ
additional i  If you selected op  I represent ar	nformation required to validate motion 2 above, please read an	d check the following a equirements to be	-	ŕ
additional i  If you selected op  I represent ar  substitute de	nformation required to validate metion 2 above, please read and warrant that I meet all of the r	d check the following a equirements to bee legislation.	s well. (Applicant Name)	ŕ
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If you selected op I represent an substitute de I understand I understand Your information	nformation required to validate motion 2 above, please read and warrant that I meet all of the recision-maker under the applicable the purpose of disclosing this pethat I can refuse to sign this constitution.	d check the following a equirements to be equisalation.  ersonal health information sent form.	s well. (Applicant Name)	's
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additional i  If you selected op I represent an substitute de I understand I understand Your information  Signature  Telephone	nformation required to validate motion 2 above, please read and warrant that I meet all of the recision-maker under the applicable the purpose of disclosing this pethat I can refuse to sign this cons	d check the following a equirements to bee legislation.  ersonal health information sent form.  Name Name	s well.  (Applicant Name)  to Veterans Affairs Canada.  (Printed)	's

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