A California Consumer Collective & Medical Marijuana Collective

PRIVACY DISCLAIMER AND AUTHORIZATION

I, _____, hereby authorize the use and disclosure of the medical information contained in the medical recommendation of my physician for medical cannabis, for the purposes of confirming that (1) I am a qualified patient under Health and Safety Code §§11362.5 and 11362.7 *et seq.,* (2) the recommendation is a true and correct copy of the record contained in my medical records maintained by the physician's office, and (3) I am a member if the nonprofit medical cannabis patients collective, Keep It Green Collective and have authorized the collective and its members to cultivate, process, transport, and store medical cannabis on my behalf, and to distribute medical cannabis to me, and other qualified patients who join the Collective. I further authorized the use and disclosure of my medical information which I have disclosed to Keep It Green Collective in connection, so long as such disclosure is pursuant to and companies with California law, whereby Keep It Green Collective may provide law enforcement and other possible safety officials non-private patient and caregiver records upon request, and private patient and caregiver records pursuant to a properly executed search warrant, or court order. This waiver shall apply to the following:

Name:_____.

Address:_____**City, State, Zip Code:**_____
Phone Number: (___)_____.
Physician's Name: _____**Physician's Phone Number:**

I understand that by signing this authorization:

*I authorize the use or disclosure of my individually identifiable personal information as described above for the purpose listed.

*I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time except, if you have already acted because of my permission. The revocation must be made in writing and will not affect information that has already been used or disclosed.

*I have the right to inspect and receive a copy of this authorization.

*I am signing this authorization voluntarily. I have had an opportunity to review this form, and confirm that it accurately reflects my wished.

*I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the personal information.

*The collective's policy on privacy is not to disclose the name or identity of any patient other than in the course of confirmation of the recommendation from any physician regarding the medical use of cannabis and as may be necessary to establish the cultivation, processing, transportation, storage and dispensing of medical cannabis to me is authorized under California medical marijuana laws. This authorization shall terminate on the expiration of my medical recommendation unless terminated sooner in writing by me.

Date: _____ **Signature:**

Print Name: