99 NORTH
MEDICAL CANNABIS DISPENSARY

37768 2nd Ave. BOX 1312 Squamish BC V8B 0A9
Membership enquiries: info@99northdispensary.com
Tel:604.892.9699 Fax: 604.892.0399
99northdispensary.com

REQUEST FOR RELEASE OF INFORMATION

TO 99 NORTH MEDICAL CANNABIS DISPENSARY

This form has been designed to ensure that confidentiality is a respected right, and to make provisions for the exchange of relevant information between service workers.

Therefore, I, _____hereby request that my:
Patient's Name

[ ] Physician's statement and/or prescription
[ ] Confirmation of membership
[ ] Confirmation of diagnosis
[ ] Other_____

be released from_____
and forwarded to 99 North Medical Cannabis Dispensary (fax 604-892-0399).

This consent is valid for one time only, and additional releases of information will require my consent. the person/organization to whom my information is being released is prohibited from further sharing without my written authorization.

PATIENT'S NAME: _____

SIGNATURE: _____

MEMBERSHIP NUMBER (IF APPLICABLE):_____

DATE: _____