AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I, _____,authorize Fp Wellness dispensary to disclose and/or release my protected health information and/or purchase information as described below to:

Name: _____Relationship (Self/Caregiver): _____

Phone: _____

Address: _____

INFORMATION TO BE DISCLOSED upon the request of the person named above:

_____

_____

_____

_____

FORM OF DISCLOSURE initials:

_____ Verbal

_____ Electronic Record

_____ Hard copy

THIS AUTHORIZATION SHALL BE EFFECTIVE UNTIL initial one:

_____ All past, present, and future periods, OR

_____ Date or event: _____ unless I revoke it.

NOTE: You may revoke this authorization at any time by notifying the dispensary, preferably in writing.

_____

Name of the Individual Giving this Authorization **Date of Birth**

_____

Signature of the Individual Giving this Authorization **Date**