MPN Society
1316 Kingsway
855-333-3420
info@medpotnow.com

REQUEST FOR RELEASE OF INFORMATION
TO THE MED POT NOW SOCIETY

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 The Med Pot Now Society (fax 604-568-1338)

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:_____