CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION

I, _____
(Name of Patient)

authorize _____
(Name of Physician)

to disclose to San Benito County Medical Marijuana Identification Card program information concerning my medical cannabis recommendation.

The purpose of the disclosure authorized in this consent is to facilitate the issuance of a Medical Marijuana Identification Card.

I understand that my medical records are protected under the Health Insurance Portability and Accountability Act (HIPAA) as described in the Code of Federal Regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Dated: _____ _____
Signature of Patient