

**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