

## CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

To be completed by applicant and given to Health Care Practitioner and Kolab Project.

I, \_\_\_\_\_ authorize \_\_\_\_\_ to disclose:

Please select:

My personal health information consisting of: dosage information of cannabis used for medical purposes, as a verification of the health care practitioner's order as required by Kolab Project Inc.

The personal health information of \_\_\_\_\_ consisting of:

dosage information of cannabis used for medical purposes, as a verification of the Health Care Practitioner's order as required by Kolab Project Inc.

**I understand the purpose for disclosing this personal health information to Kolab Project. I understand that I can refuse to sign this consent form.**

**Note:** A substitute decision maker is a person authorized under PIPEDA to consent, on behalf of an individual, to disclose personal health information about the individual.

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## PERSONAL INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
Primary Phone \_\_\_\_\_ Email Address \_\_\_\_\_  
Signature \_\_\_\_\_  
Date \_\_\_\_\_

Please submit a copy of this form to your Kolab Care Team by email at kolabcare@kolabproject.com, as well as to your Health Care Practitioner.