Cannabis Control Commission
COMMONWEALTH OF MASSACHUSETTS

Authorization for Release of Information Medical Use of Marijuana Program

If you want the Medical Use of Marijuana Program to share confidential information about you with another person or organization, please fill out all the sections below, which will tell us what information you want us to share and who to share it with. If you leave any sections blank, your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

Section I.

I, _____, give permission for the Medical Use of Marijuana Program to
[name]
share the information about me that I list in Section II with the person(s) or organization that I list in Section IV.

Section II. Confidential Information (G. L. c. 94I § 3 and 935 CMR 501.200)

Information to be Released (please check all that apply):

- ☐ Complete Medical Record
- ☐ Registration and Certification History
- ☐ Dispensing History
- ☐ Other (please specify below):

Section III. Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list the reason(s), you may simply write "I choose not to state."

Section IV. Who May Receive My Information

To whom you would like the information sent:

_____

Name

_____

Organization

_____

Address

_____

_____

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

Section V. How Long This Permission Lasts

This permission to share my information is good until _____.
[date or event]

If I do not list a date or event, this permission will last for one year from the date it is signed.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to the Cannabis Control Commission, 101 Federal St., 13th Floor, Boston MA 02110, Attention: Privacy Officer. If the information has already been given out, I understand that it is too late for me to cancel the permission.
- I understand that if I choose not to give this permission or if I cancel my permission, I may still be able to receive any services that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

Section VI. Signature

Please sign and date this form and print your name.

_____ _____

Your Signature Date

_____

Print Your Name

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court-appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Describe how this person has legal authority for this individual: _____

Please retain a copy of this completed form for your personal records.