Medical Treatment Authorization & Consent Form

Pursuant to Health Information Protection Act, 2005 (HIPA) | Version 1.2 Oct 2013

I_____ give full authorization to my Substitute Decision Maker, _____ to communicate and work with Apollo Applied Research Inc. and (Apollo Cannabis Clinics and Apollo Marijuana Clinics) to collect my medical health information & documentation regarding my condition(s). My Substitute Decision Maker may act as my representation and decision maker for an appointment with my physician at the Apollo Applied Research Clinic, if I am unable to attend due to my medical condition.

To be completed in full by patient (or person authorized under HIPA to consent on behalf of an individual to disclose personal health information about the patient which would be a substitute decision maker).

Patient Information

_____ _____ _____
Given Name | Surname | Date of Birth (mm/dd/yyyy)

_____ _____
Number and Street Name | Apartment/Unit Number

_____ _____ _____
City | Province | Postal Code

_____ _____ _____
Home Telephone | Cell Phone | Work Telephone

_____ _____
Signature (patient or substitute decision maker) | Date (mm/dd/yyyy)

Caregiver / Decision Maker

_____ _____ _____
Given Name | Surname | Date of Birth (mm/dd/yyyy)

_____ _____
Number and Street Name | Apartment/Unit Number

_____ _____ _____
City | Province | Postal Code

_____ _____ _____
Home Telephone | Cell Phone | Work Telephone

_____ _____
Caregiver Signature | Date (mm/dd/yyyy)