Fax form to: 866.821.0777
or email to: info@apolloresearch.ca
P: 416 840 5991 F: 866 821 0777
TOLL FREE: 1 877 560 9195

Medical Treatment Authorization & Consent Form

Pursuant to The Personal Health Information Proterction Act (PHIPA)

I ______________________ give full authorization to my representative, ______________________ to communicate and work with Apollo Applied Research Inc. and Apollo Cannabis Clinics to collect my medical health information & documentation regarding my medical condition(s). My representative may act as my representative, to communicate with my healthcare practitioner on my behalf during appointments, whether held in person or by telemecine, at the Apollo Cannabis Clinics, 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).

Patient Information:

Given Name: ______________ Surname: ______________ DOB: __________
MM/DD/YYYY

Address # and Street Name: ______________ Apt/Unit Number: __________

City: ______________ Province: ______________ Postal Code: __________

Home Telephone: ______________ Cell Phone: ______________ Work Telephone: __________

Signature: ______________ Date: __________
MM/DD/YYYY

Representative Information:

Given Name: ______________ Surname: ______________ DOB: __________
MM/DD/YYYY

Address # and Street Name: ______________ Apt/Unit Number: __________

City: ______________ Province: ______________ Postal Code: __________

Home Telephone: ______________ Cell Phone: ______________ Work Telephone: __________

Representative Signature: ______________ Date: __________
DD/MM/YYYY

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