**CONSENT FOR THE RELEASE**

**OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Patient)

authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Physician)

to disclose to the Yolo County Health Department Medical Marijuana Identification Card program verification concerning physician recommendation for medical use of marijuana.

The purpose of the disclosure authorized in this consent is to facilitate the issuance of Medical Marijuana Identification Card.

I understand that my medical records are protected under the Health Insurance Portability and Accountability Act (HIPPA) as described in the codes 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 to the extent that action has been taken in reliance on it.

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Date Patients signature

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