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## Release of Confidential Medical Information Form

Date: \_\_\_\_\_

I, \_\_\_\_\_, do hereby grant permission for the release of my confidential medical information to MedCannAccess. I give permission for the Physician noted below to verify my medical status with the office of MedCannAccess by telephone or fax. MedCannAccess agrees to use this information for the sole purpose of determining eligibility and also agrees to keep this information strictly confidential.

Signature: \_\_\_\_\_

Current Physician's Name: \_\_\_\_\_

Physician's phone number: \_\_\_\_\_