OCEAN GROWN +
MEDICINAL SOCIETY

Ocean Grown Medicinal Society
1-1725 Cook Street,
Victoria, BC V8T 3P4
P: 778.265.1009
F: 778.265.1040

Request for Release of Information

Dear Health Care Practitioner,

This form has been designed to ensure that confidentiality is a respected right, and to make provisions for the exchange of relevant information between services workers.

Therefore, I _____ hereby request that my:
Patient's Name

- ◯ Physician's statement and/or prescription
- ◯ Confirmation of membership
- ◯ Confirmation of diagnosis
- ◯ Other _____

Be released from: _____ and forwarded by fax directly to

Ocean Grown Medicinal Society: 778 265 1040

This consent is valid for one time only, and additional releases of information will require my consent. The person/organization to which my information is being released is prohibited from further sharing without my written authorization.

_____ _____
PATIENT'S SIGNATURE: **DATE**

_____ _____
PRINTED NAME: **MEMBERSHIP NUMBER: (IF APPLICABLE)**