#1-518-304 ST Kimberley, BC V1A 3H5
BUS: 778.481.5297 FAX: 778.481.5293
Membership inquiries:
membership@tamarackdispensaries.ca
Canada-wide delivery

REQUEST FOR RELEASE OF INFORMATION

To TAMARACK DISPENSARIES;

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

Therefore, I, ____ hereby request that my:

- ☐ Physician's statement and/or prescription
- ☐ Confirmation of membership
- ☐ Confirmation of diagnosis
- ☐ Other ____

be released from ____

and forwarded to **Tamarack Dispensaries (fax 778.481.5293).**

This is ROI is intended for those seeking membership within Tamarack Dispensaries.

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

PATIENT'S NAME: ____

SIGNATURE: ____

MEMBERSHIP NUMBER (IF APPLICABLE): ____________________________

DATE: ___________________________