ORGANIGRAM

Questions?
Email: info@organigram.ca
Toll-Free: 1-844-644-4726
Fax: 1-855-267-1386

Health Care Authorization Form

Thank you for choosing Organigram as your medical provider. Before we can authorize the shipment of your medicine to a Health care facility, we will require a person responsible from the facility attesting the permission to receive. You will need to complete the following application.

Important, please read and sign below:

I, ______________________ attest that I provided ______________________
(Health Care Practitioner) (Patient's Name)

with his/her medical document and that I consent to receiving this patient's prescribed medical cannabis at my facility/clinic.

Signature of Health Care Practitioner: ______________________ Date : __________

Signature of Patient: ______________________ Date : __________

By signing, I hereby designate the above health care practitioner's address as the shipping address for my medical cannabis.

Notice to the Health Care Practitioner in case of withdrawal of consent:

If the health care practitioner ceases to consent and receive dried cannabis for the patient, the practitioner must send a written notice to that effect to the patient and the licensed producer.

Health Care Practitioner Information

Full Name:	Title:
Name of establishment:	Phone Number:

- [ ] Same as Business Address provided on medical document
- [ ] Same as Consultation Address provided on medical document
- [ ] Other: Please provide below

Address:	City:
Province:	Postal Code: