IOWA Health and Human Services

Bureau of Cannabis Regulation Release of Information Authorization

- Completing this form allows Iowa Department of Health and Human Services Bureau of Cannabis Regulation (HHS-BCR) to share information with the individual you identify below.
- Your services or benefits will not change if you do not sign this form or give permission to share your information.
- HHS-BCR will not release information if prohibited by state or federal law.
- Iowa HHS cannot promise that the person or group you allow us to share your information with will not share it with someone else.

Requestor Information

Full Name: _____

Patient Registry Number: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email Address: _____

Person Authorized to Receive Information

Information may be released to _____

Description of Information to be Disclosed

☐ Verification of Medical Cannabidiol Registration Card

☐ Other: _____

Purpose of Disclosure

☐ Coordination of care ☐ Verification of Medical Cannabidiol Registration Card

☐ Other: _____

Expiration of Authorization

This authorization expires (choose one):

☐ Specific date:

☐ Upon expiration or cancellation of medical cannabidiol card.

I understand that I may revoke this authorization at any time by providing written notice.

Signature

Signature: _____ Date: _____

(Signature of Individual or Legal Representative*)

*Legal Representatives: If you are the legal representative to the person named above, please include copies of those forms (such as power of attorney or guardianship) with this release.