apollo™ Cannabis Clinics

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Medical Treatment Authorization & Consent Form

Pursuant to Health Information Protection Act, 2005 (HIPA)

I _____ give full authorization to my representative, _____ to communicate and work with Apollo Applied Research Inc. and Apollo Cannabis Clinics to collect my medical health information & documentation regarding my medical condition(s). My representative may act as my representative, to communicate with my healthcare practitioner on my behalf during appointments, whether held in person or by telemecine, at the Apollo Cannabis Clinics, if I am unable to attend due to my medical condition.

To be completed in full by patient (or person authorized under HIPA to consent on behalf of an individual to disclose personal health information about the patient).

Patient Information:

Given Name: _____ Surname: _____ DOB: _____ MM/DD/YYYY

Address # and Street Name: _____ Apt/Unit Number: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone: _____ Cell Phone: _____ Work Telephone: _____

Signature: _____ Date: _____ MM/DD/YYYY

Representative Information:

Given Name: _____ Surname: _____ DOB: _____ MM/DD/YYYY

Address # and Street Name: _____ Apt/Unit Number: _____

City: _____ Province: _____ Postal Code: _____

Home Telephone: _____ Cell Phone: _____ Work Telephone: _____

Representative Signature: _____ Date: _____ DD/MM/YYYY

