AUTHORIZATION TO DISCUSS HEALTH CARE INFORMATION

We are committed to the privacy of your health information. Please read this form carefully. Your signature/initials below indicates your approval.

WCM created the Mark Bushey Compassion Program to provide high quality cannabis therapies at no cost, for patients who meet the Medicare definition for hospice care.

In order to best serve you, staff of the Mark Bushey Compassion Program at WCM need to be aware of certain details of your medical status. These details may include, but are not limited to:

- Status as a hospice patient under Medicare definitions
- Primary and secondary healthcare conditions
- Other treatments, services, supplies and medicines you are using

I, ____, hereby authorize the Mark Bushey
Print Patient's Name

Compassion Program at WCM to contact the following persons or entities to discuss my Medicare hospice diagnosis and related medical information in my hospice record (such as my medical plan of care):

◯ My guardian or DPOA (name) ____
◯ My primary and/or other physicians
◯ My hospice nurse, social worker, and/or volunteer

I authorize this access to information concerning my physical and mental condition for the limited purpose of determining eligibility for Program services and to provide the best possible continuity of care.

Information to be released/discussed will not be further disclosed, nor used for any purpose other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be in writing, signed by me or my legal representative. No written revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto. I understand that I have the right to inspect and copy any information released in written form. I further understand that refusal to consent to the release of information specified will prevent disclosure of such information to the Mark Bushey Compassion Program, and may result in the program being unable to establish eligibility to receive services. This authorization is valid until ___________________________________, being one year from today's date.

Patient Signature/Date	Guardian/Power of Attorney Signature/Date
Internal Use: WCM Member ID	Relationship of Person Above to Patient