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 cannabis 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 _____
(Health Care Practitioner) (Patient's Name)

may receive their prescribed medical cannabis at our facility/clinic.

Signature of Health Care Practitioner: _____ Date:_____

Signature of Patient: _____ Date:_____

Notice to the Health Care Practitioner:
Withdrawal of consent by the Health Care Practitioner:
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:

Title:

Phone Number:

☐ Same as Business Address provided on medical document

☐ Same as Consultation Address provided on medical document

☐ Other:
Please provide below

Address:

Postal Code:

City:

Province: