

## Authorization to Release PATIENT CARD HOLDER STATUS

Please complete and return this form by mail to: Office of Medical Cannabis, 350 Capitol Street, Room 523, Charleston, WV 25301 or by email to: medcanwv@wv.gov.

PATIENT/CAREGIVER INFORMATION:			
PATIENT ID NUMBER: _____		CAREGIVER ID NUMBER (if applicable): _____	
Full Legal Name:			Date of Birth:
Patient Address:			
City:	State:	County:	Zip:
Phone Number:		Email:	
<p>I hereby authorize the Office of Medical Cannabis to release the status of my medical cannabis patient and/or caregiver participation as a current (valid) or invalid card holder in the State of West Virginia to the following:</p> <p><input type="checkbox"/> Business      <input type="checkbox"/> Individual</p> <p>Name/address/email and phone number of entity/person to be released to:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>			
REQUIRED SIGNATURE: Patient/Parental Custodian/Legal Guardian (If qualifying patient is under 18)			
Print Full Legal Name (First, Middle, Last):			Date:
Signature:			

**FOR OMC OFFICE USE ONLY**

This card is currently:  Active       Inactive

Information provided has been verified by:	Title:	Date: