CANNABIS
TREATMENT
CLINIC

Consent Form

One of our objectives at Cannabis Treatment Clinic (**"we", "us"** or **"our"**) is to ensure that each of our patients understands and is informed about all aspects of our services, including how we collect, use and disclose personal information (**"PI"**) and personal health information (**"PHI"** and together with **"PI", "Personal Information"**)

In order to live up to this objective, and to sure that we comply with applicable privacy laws in connection with the services we provide, we ask that you please complete and sign this Consent Form. By signing this form, you will, among other things, be providing us with your acknowledgement and consent to our collection, use and disclosure of your Personal Information, as set forth in this Consent Form (**"Personal Information Practices"**).

You may revoke your consent to any or all of these Personal Information Practices at any time by providing us with written notice of the withdrawal of your consent. Please note, however, that the withdrawal of your consent to any Personal Information Practice may render us unable to continue providing you with our services.

Should you have any questions about our Personal Information Practices, please feel free to write or email us at Attention: Privacy Officer, Cannabis Treatment Clinic, 7191 Yonge Street – Suite #508, Thornhill, Ontario, L3T 0C4, info@ctclinic.ca

I, _____ (print name), hereby consent and/or agree to the following Personal Information Practices:

☐ Yes	☐ No	To the collection, use and disclosure of my Personal Information for purposes of providing health care services, clinic operations and payment activities.*
☐ Yes	☐ No	To my doctor and Cannabis Treatment Clinic communicating with me by email at the following email address: _____ (print email address). With respect to email communications, I acknowledge and agree: (i) that the security of emails is not guaranteed and may be accidentally forwarded or shared; (ii) that I will only share information in email that I am comfortable sharing via email; (iii) to notify my doctor and Cannabis Treatment Clinic if there is any information that do not want shared by email; (iv) to not use email in the case of an emergency as email may be delayed in being sent or received.
☐ Yes	☐ No	To participate in free cannabis counselling and education services (**"Counselling Services"**) offered by GreenTx Inc. ("**GreenTx**") in the event that I am given a medical document (prescription) for medical cannabis. The Counselling Services include, without limitation: (i) cannabis education; (ii) demonstrations on using vapourizers; (iii) strain selection guidance; and (iv) assistance registering with the Licensed Producer of my choice. By giving this consent, I also consent to Cannabis Treatment Clinic, and my doctor, sharing Personal Information with GreenTx solely to the extent necessary to provide me with the Counselling.

☐ Yes	☐ No	I acknowledge and agree that participation in the Counselling Services is entirely voluntary. In the event that I agree to participate in the Counselling, I understand that my medical document will be provided directly to my counsellor in connection with the Counsellor. In the event that I opt not to participate in the Counselling, the medical document will be provided directly to me and I will be solely responsible for registering with and ordering from a Licensed Producer.
☐ Yes	☐ No	I understand and acknowledge that the cost of providing the Counselling Services is paid for by certain Licensed Producers who have entered into an agreement with GreenTx (**"Education Agreements"**). Among other things, these Education Agreements enable GreenTx to provide me with up-to-date information on strains and availability of such Licensed Producers. Not all Licensed Producers in Canada have entered into such an agreement. Notwithstanding, I understand that I am free to request registration with any Licensed Producer authorized by Health Canada and my counsellor will assist with me with registering with any Licensed Producer of my choosing.

Date: _____ Signature: _____

Representative Signature (if necessary): _____

*Without this consent, we will not be able to provide you with any services. All other consents are optional.