



New Mexico Department of Health Medical Cannabis Program
Participant Consent to Release Medical Information to Primary Caregiver

I, _____ authorize the New Mexico Department of Health Medical Cannabis Program to discuss my medical condition with _____, my primary caregiver under the NMDOH Medical Cannabis Program. I understand I may revoke this release at anytime and the medical information shared between the Medical Cannabis Program and my primary caregiver will pertain to my enrollment in the Medical Cannabis Program and on a need-to-know basis only.

This authorization will expire one (1) year from date of signature, unless otherwise specified below.

Signature:
Participant or Personal Representative: _____

Date: _____

Expiration Date: _____