I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that this Release and Acknowledgement contains valuable information about possessing/cultivating and consuming prescribed medical cannabis, that the assessing specialist/physician/Nurse Practitioner requires to issue a medical document for the access to cannabis for medical purposes regulations (ACMPR). I also understand that the consulting specialist/physician/Nurse Practitioner will not necessarily be assuming primary care for me, but only be recognized as my ACMPR prescribing practitioner. I understand and agree to continue to regularly see my primary care physician for my medical conditions on a regular basis and notify them of my medical use of cannabis.

The specialist/physician/Nurse Practitioner will way the risks versus the rewards in treating my medical condition(s) and their symptoms associated, with medical cannabis. I confirm that the assessing specialist/physician will be the only practitioner providing a medical document under the ACMPR for the purpose of possessing/cultivating and consuming medical cannabis.

I agree to make no claims or commence any legal action against the assessing specialist/physician, my family physician or any other involved physicians in regard to:

a) My consumption of medical cannabis

b) My Application or medical document(s) for possessing, obtaining, cultivating and consuming medical cannabis

I am aware that specialists/physicians generally agree that medical cannabis:

-May effect sight, sounds and touch

-May impair thinking, problem-solving, coordination, memory and learning

-May increase heart rate and reduce blood pressure

-May induce anxiety, fear, distrust, or panic

INITIAL \_\_\_\_\_\_\_\_\_\_\_\_

I am aware that medical conditions such as schizophrenia, atrial fibrillation, Heart attack/stroke or use of blood thinners may result in a denial for my application to possess and consume medical cannabis. I am also aware that if pregnant or planning to become pregnant that medical cannabis should not be consumed during pregnancy or while breastfeeding.

INITIAL \_\_\_\_\_\_\_\_\_\_\_

FOR PATIENTS Pursuing an ACMPR Medical Document

I am aware of the considerable debate and a lack of consensus among specialists and physicians about;

-The appropriate dose and medical use of cannabis

-The risks of burning medical cannabis as compared to vaporizing or ingesting

-The risks of burning extracted cannabinoids such as oils or hashish

-The long term psychological and health risks associated with medical cannabis

-The risk of pulmonary infections and respiratory cancer

-The risk of triggering mental illness, such as bipolar disorder and schizophrenia

-The risk of nausea and disorientation

INITIAL \_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent to the disclosure and sharing and use of my personal information and personal health information by the assessing specialist/physician/Nurse Practitioner, InfoCannabis, and my licensed producer. The information may be used to contact and register the patient. The information may also be used for analytical and research purposes.

INITIAL\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ truly believe that treating my personal medical condition(s) with medical cannabis potentially or has had a positive effect and the benefits outweigh the risks associated.

INITIAL\_\_\_\_\_\_\_\_

This is my personal decision to possess and consume medical cannabis and I do not support any claims made by family, friends or other individuals against InfoCannabis or the prescribing specialists/physicians.

INITIAL\_\_\_\_\_\_\_\_

I hereby release InfoCannabis, the assessing specialist/physician, from any and all claims, actions, causes of actions, complaints (including friends and family) and demands for damages, loss, or injury arising directly or indirectly to my use of medical cannabis and my Application to possess, cultivate or consume medical cannabis.

INITIAL\_\_\_\_\_\_\_\_

This release from liability is to be binding on heirs, executors and signs and I acknowledge that I have the right to refuse to sign this form.

INTIAL\_\_\_\_\_\_

PRINT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WITNESS PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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