DESIGNATED PROVIDER AUTHORIZATION

Pursuant to the Washington Medical Cannabis Act RCW 69.51A

_____	_____
Patient Name	Designated Provider Name
_____	_____
Patient Address	Designated Provider Address
_____	_____
City, Zip	City, Zip
_____	_____
Patient Phone #	Designated Provider Phone #

AGREEMENT

The above named patient hereby authorizes the above named Designated Provider as his/her legally recognized Designated Provider as stipulated under RCW 69.51A and this document is a legally binding contract between the parties. The patient hereby authorizes the Designated Provider to obtain, grow, secure, prepare, repackage and transport medical cannabis for the patient. This agreement further authorizes the Designated Provider to obtain, secure and transport any other medications recommended or prescribed by the Patients medical providers.

This agreement becomes effective upon execution by the patient and expires upon either the patient's written revocation of the agreement by the patient, expiration date of medical recommendation or upon the patient's death.

This agreement is non transferable, assignable, or otherwise extended to assignees or designates.

The patient agrees to defend and hold harmless the Designated Provider. I further testify that I am of sound mind at the time of this agreement and have been given an opportunity to review this document prior to signing and authorizing the above said agreement.

ATTENTION LAW ENFORCEMENT

I am the legal Designated Provider for _____, a legal medical cannabis patient, as defined by the Washington Medical Cannabis Act, RCW 69.51A. I have attached a copy of the patient's medical cannabis recommendation as required with RCW 69.51A. Green Medical Group can be reached by phone at (425) 306-4895 or by fax at (425) 354-5699 OR (425) 412-6887.

I have attached a copy of my Washington State Driver license/id card, as well as a copy of the patient's Washington State identification. I have also attached a copy of the document signed by the patient authorizing me as his/her legal Designated Provider.

I am in possession of less than this patient’s necessary “60 day Supply” as defined by RCW69.51A. I will not answer any questions relating to my patient’s status as a qualified patient, their medical condition, their dosage requirements or the number of plants that this patient needs as their “60 day Supply” or any other questions regarding my patient’s medical condition or medication. This information is confidential and is strictly protected under the Federal HIPAA law that protects the confidentiality of my patient’s medical information. Requesting this information, without a subpoena, violates my patient’s State and Federal rights, as well as my own.

I will not speak with you unless I am accompanied by my attorney. Any further attempt to speak with me without the presence of my attorney will be considered coercion. I do not, and will not, agree to a search of my home, person, property, or vehicle under any circumstances without a search warrant.

The attached documents are being provided for your records and incident report. I encourage review of this documentation before taking action.

_____	_____
Patient Signature	Designated Provider Signature
_____	_____
Date Signed	Date Signed