Consent Form to Release Your Private Data

If you want MDH to release private data about you to another person or organization, MDH needs written permission (informed consent) from you to authorize that release. This form can be used to provide informed consent for MDH to release your private data to another person or organization.

If you have a question about this form or would like more explanation before you sign it, please contact the Office of Medical Cannabis. **Email completed request forms to health.cannabis@state.mn.us**, or mail to:

Office of Medical Cannabis
PO Box 64975 OLF-4C
St. Paul, MN 55164-0975

Phone: 651-201-5598

Explanation of your rights and permission to release private data

I, _____ *[name of individual data subject]*, born on _____ [*data subject date of birth]*, give permission to the Minnesota Department of Health ("MDH") to release data about me to _____ *[name of the person or organization receiving the data]* as described in this consent form.

1. The specific data I want MDH to release is my: (*check all that apply)*
   - ☐ Registry enrollment verification
   - ☐ Medication dispensing history
   - ☐ All Office of Medical Cannabis records
   - ☐ Certifying medical condition(s)
   - ☐ Other *[please describe below]*
2. I want MDH to release the data to the above named person or organization, using the following contact information: *[provide the email address and/or mailing address]*
3. I understand that I have asked MDH to release my data to the person or organization named above.
4. I understand that some or all of the data I have asked MDH to release may be classified as private under the Minnesota Government Data Practices Act (Minnesota Statutes, chapter 13). Private data may only be accessed by the data subject and persons authorized by the data subject, except as allowed by law.
5. I understand that although some or all of the data are private at MDH, the way these data are classified or treated by the above named person or organization receiving the data will depend on the laws and policies that apply to that organization.

This permission to release expires _____ [*date/time of expiration*]

A photocopy is as valid as an original.

Individual Data Subject Signature: _____

Date: _____

Verification of identity

MDH needs to verify that you are the data subject and person who has the right to authorize release of this data. One way to do this is to provide a notarized signature using the section below. If you have questions about other ways to verify your identity, please email Health.Cannabis@state.mn.us.

STATE OF _____ } SS.

COUNTY OF _____

On _____, 20 _____ , before me, a notary public for said state, personally appeared

_____, personally known to me or proved to be such person by proper proof,

and acknowledged that s/he executed this Verification of Identity.

_____

Notary Public Signature

SEAL:

For internal MDH use only: *If this form does not include a notarized signature, please provide a brief explanation of how the requester's identity was verified:*

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