Montana Medical Marijuana Program
Authorization to release information

I give Montana's Medical Marijuana Program permission to release the following information:

_____

_____

_____

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_____

This information may be released to the following individuals/entities:

_____

_____

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_____

_____

_____

This authorization expires one year from the date I signed this authorization. I understand I can submit a written request to revoke this consent at any time.

_____ _____

Name (printed) Phone

_____

Street Address City Zip Code

_____ _____

Signature Date

12/30/2020