LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Michigan Medical Marihuana Program
Release for Disclosure of Information

www.michigan.gov/mmp
(517) 284-6400

Instructions

1. Complete all pages of the form and have all authorizing signatures **notarized**. Forms must be signed & notarized within 90 days from the date the form is received in our office.
   - **SECTION A** – Enter the information requested on lines 1–7. You may only request information and/or documents pertaining to your own Michigan Medical Marihuana Program (MMMP) records.
   - **SECTION B** – Designate the person you are authorizing MMMP to release records to on line 8 and include the recipient's contact information on lines 9–12. If you are requesting the records for yourself, simply write "same as above" on line 8. Check the appropriate box on line 13.
   - **SECTION C** – Check the appropriate box (you may check more than one) and include a specific date or date range. If you are requesting MMMP records, describe the documents you are authorizing MMMP to release to the designated recipient in section B.
   - **SECTION D** – Read the information regarding the conditions under which the records will be released to the designated recipient.
   - **SECTION E** – Sign and date to authorize MMMP to release the records to the designated recipient. You must sign and date this section in the presence of a notary public. The signature and notarial act must be within 90 days from the date the form is received in our office.
   - **SECTION F** – To obtain unredacted copies of any physician certifications in the file, have the certifying physician sign and date this section in the presence of a notary public to authorize MMMP to release his/her information. Make a blank copy of page 4 if more than one physician is completing this section.
   - **SECTION G** – To obtain unredacted documents containing information for persons other than yourself, such as the caregiver if you are a patient and vice versa, those persons must authorize the release of their information by signing and dating this section in the presence of a notary public. Make a blank copy of page 4 if more than one person is completing this section.
2. Mail the completed form and a legible copy of your valid driver's license or State-issued personal identification card with photo to:

Michigan Medical Marihuana Program
P.O. Box 30083
Lansing, MI 48909

Section A – Person Authorizing Release

1. Legal First Name	2. Middle Initial	3. Legal Last Name 3b. Suffix (Jr., Sr.,etc.)
4a. Mailing Address		4b. Apartment/Suite/Lot #
5. City	6. State	7. Zip Code

Section B – Designated Recipient

8. Recipient's Name (First, Middle, Last)			
RECORDS DEPOSITION SERVICE, INC.			
9. Recipient's Mailing Address	10. City	11. State	12. Zip Code
P.O. BOX 5054	SOUTHFIELD	MI	48086-5054

13. Select how you would like the records to be sent to the recipient:

☐ Via first class mail to the recipient's mailing address (above)

☐ Via facsimile or email to the following number or address: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

Section C – Records to Be Released

PLEASE CHECK THE APPROPRIATE BOX(ES):

☑ **Verification of Status of Registry Card(s) - These requests will be given priority. Check one of the boxes below.**

☐ Please provide a verification of whether I *currently hold* a valid registry card.

☐ Please provide a verification of whether I *held* a valid registry card on _____ (date) **OR** from _____ (date) to _____ (date).

☑ **Detailed Registration History – Allow a minimum of 2 weeks for a response.**

- Please provide a certified record of my registration history from _____ (date) to _____ (date).

☑ **MMMP Records – Allow a minimum of 2 weeks for a response.**

- Please provide copies of the following documents on file with MMMP (Note: documents containing information for persons other than yourself will be redacted, unless those persons have properly completed Sections F and/or G):

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Section D – Release for Disclosure of Information

I authorize the Michigan Department of Licensing and Regulatory Affairs (LARA), or its successor department, to release Michigan Medical Marihuana Program (MMMP) records in accordance with sections A – C of this form, which may include patient, caregiver, and/or physician identifying information. I understand that identifying information for any other individuals will be *redacted* from the records provided unless such individuals properly complete sections F and G of this form.

I represent that I have provided proper identification to the notary public upon signing this form. Proper identification consists of a valid driver's license and/or State-issued personal identification card with photo. If I do not possess one of the named forms of identification, I represent that I provided a copy of my birth certificate *and* social security card to the notary public for purposes of identification.

I, my successors, heirs, assigns, and any other persons or entities who could lawfully make a claim on my behalf, release and hold harmless LARA, or its successor department, including but not limited to each of its divisions, agencies, commissions, officers, and employees, and the successors, heirs, and assigns of such persons and entities, from any and all rights, actions, grievances, claims, liabilities, demands, suits, and causes of action, based on any grounds for relief, whether in law or equity, under state or federal law, of each kind, nature, and description, whether known or unknown, suspected or unsuspected, that either may have, now or in the future, against the above listed entities and persons as a result of or arising out of the disclosure by LARA, or its successor department, of the requested information and/or documents.

I represent and warrant that, based upon a reasonably diligent inquiry and the advice of counsel, if any, I have legal authority to sign this form, and that I bear sole responsibility for any mistake regarding my legal authority to sign this form. I further represent and warrant that I have either reviewed or had the opportunity to review the Michigan Medical Marihuana Act, MCL 333.26421 *et seq.*, and associated administrative rules, which are available on MMMP's website or upon request to MMMP.

I understand that if any portion of this form is not completed in accordance with the instructions, this request for MMMP records will be DENIED.

Section E – Your Signature

I represent and acknowledge that I have read, understand, and agree with Section D, regarding my request for release of my MMMP records as described in Section C of this form.

_____
PRINT NAME of Person Authorizing Release

_____ _____
Signature of Person Authorizing Release Date

THIS SECTION MUST BE NOTARIZED WITH PROPER IDENTIFICATION (AS DESCRIBED IN SECTION D) PROVIDED TO A NOTARY PUBLIC

Subscribed and sworn before me this
_____day of _____, 20____

_____Notary

_____County, State of _____

My commission expires_____

Section F – Authorization to Release Personal Information and Unredacted Records Certifying Physician

I represent and acknowledge that I have read, understand, and agree with Section D, regarding _____'s (fill in name of Person Authorizing Release) request for release of his/her MMMP records as described in Section C of this form, which may include my identifying information as the certifying physician.

_____
PRINT NAME of Certifying Physician

_____ _____
Physician Signature Date

THIS SECTION MUST BE NOTARIZED WITH PROPER IDENTIFICATION (AS DESCRIBED IN SECTION D) PROVIDED TO A NOTARY PUBLIC

Subscribed and sworn before me this
_____day of _____, 20____

_____Notary

_____County, State of _____

My commission expires_____

Section G – Authorization to Release Personal Information and Unredacted Records Other Signature

I represent and acknowledge that I have read, understand, and agree with Section D, regarding _____'s (fill in name of Person Authorizing Release) request for release of his/her MMMP records as described in Section C of this form, which may include my identifying information.

_____ _____
PRINT NAME Relationship to Person Authorizing Release (e.g., patient, caregiver, etc.)

_____ _____
Signature Date

THIS SECTION MUST BE NOTARIZED WITH PROPER IDENTIFICATION (AS DESCRIBED IN SECTION D) PROVIDED TO A NOTARY PUBLIC

Subscribed and sworn before me this
_____day of _____, 20____

_____Notary

_____County, State of _____

My commission expires_____