Privacy Policy Acknowledgement Statement

I hereby acknowledge that I have been made aware that Affinity Dispensary has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1993 (HIPAA).

As a patient at Affinity Dispensary, I understand and acknowledge the following:

1. Affinity Dispensary has a Privacy Policy in effect in their office.
2. Affinity Dispensary has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room and/or by placing a poster version of this policy in the waiting room or similar area with patient access and/or having a copy available for download and review on their website.
3. Affinity Dispensary has made me aware that as a patient I am entitled to a copy of this Privacy Policy, if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the Privacy Policy implemented by Affinity Dispensary and have read and understand the acknowledgement form. If you desire a copy of the Privacy Policy, please request one at this time or download a copy from our website at www.affinityct.com.

_____ NO, I do not want a copy, but acknowledge that the Privacy Policy exists. **Patient Initials _____**

_____ YES, I DO want a copy of the Privacy Policy and I received the requested copy. **Patient Initials _____**

Patient Name: _____ Patient Signature: _____ Date: _____

Release of Liability

I hereby acknowledge that Affinity Dispensary and its employees are not addressing specific aspects of my medical care nor are any of them my primary care provider. Furthermore, I, for myself, my heirs, assigns, or anyone acting on my behalf, hold Affinity Dispensary and its principals, agents, and employees free of and harmless from any responsibility for any harm resulting to me and/or other individuals as a result of my cannabis use. **Patient Initials _____**

I certify that I fully understand the potential risks and side effects related to the use of cannabis as described above.
Patient Initials _____

In using cannabis for medicinal use, I fully accept responsibility and assume the risks and side effects associated with its use.
Patient Initials _____

I agree that Affinity Dispensary and its employees shall not be held responsible for any harm resulting to me and/or any other individual(s) as a result of my medicinal usage of cannabis. **Patient Initials _____**

I certify that I have read this document and declare under penalties of perjury that the information contained herein is true, correct and complete. **Patient Initials _____**

Patient's Signature: _____ Date: _____