

New MexiCann Natural Medicine
PO Box 5497 • Santa Fe, NM • 87502
901 W. San Mateo Rd, Suite B, Santa Fe, NM
(505) 982-2621

Thank you for your interest in New Mexicann Natural Medicine. We are a licensed provider of organic, medical cannabis in the State of New Mexico. Our carefully selected plants are chosen to provide the greatest range from among the various strains and blends of the Indica and Sativa forms of cannabis to ensure that we have a variety suitable for your medical needs.

If you are a licensed patient or caregiver and wish to purchase from New Mexicann Natural Medicine, you will need to complete the Client Information form and return this, along with a photocopy of your Licensed Patient card and Federal or State government issued photo identification (i.e. a New Mexico driver's license or passport. *If faxing your I.D. and DOH cards, please send them in color, if that option is available on your fax machine.*

We will also be available at our office at 901 W. San Mateo, Suite B, on Wednesday and Thursday, 10:30 a.m. -12:30 p.m. and 1:30 p.m. -3:30 p.m. if you wish to return your forms in person, have questions or want to meet some of our staff.

New Mexicann Natural Medicine is striving to offer the community current and accurate information and assistance through our website and newsletters. Please take the time to sign up at NewMexicann.org as a way for you to communicate with us and with other patients. To further foster community, New Mexicann employs patients and volunteers whenever possible which helps us provide understanding and a sympathetic ear whenever you contact us. We welcome any suggestions of how we might better serve the community.

Thank you for your interest in New Mexicann Natural Medicine. We look forward to hearing from you and serving you in the future.

Sincerely,

The Staff at New Mexicann Natural Medicine

Len, Blaine, Jay, Susan, Jennifer, Kevin, Judy and Carlos

New MexiCann Natural Medicine
Licensed Patient or Caregiver Registration Form

(Please Print)

Name: *First:* _____ *Last:* _____

Home Address: _____ Apt. #: _____

City: _____ Zip: _____

Delivery Address (*check one*): *Same as Home* *Other:*

Street: _____ Apt. #: _____

City: _____ Zip: _____

Home Phone: _____ Alt #: _____

Email Address: _____

Emergency Name: _____ Phone: _____

How may we contact you? Phone Mail Email May we leave phone messages? Yes No

If yes, I authorize NewMexiCann Natural Medicine to leave messages with my caregiver or at: Home # Alt #

Dept. of Health I.D. #: _____ Exp. Date: _____

- I understand and agree that medical cannabis received from New MexiCann Natural Medicine is for the exclusive use of the approved applicant and may not be resold or given to any person.
- I understand that the corporation reserves the right to refuse service to anyone whom in its opinion may be in violation of NM medical cannabis law and/or NM Dept. of Health medical cannabis rules and regulations.
- I agree to notify the corporation of any changes in my status in the NMDOH Medical Cannabis Program, any change in my condition for which medical cannabis is recommended, any change in my contact or delivery information and any change in my listed physicians.
- I understand and agree to abide by all applicable NM medical cannabis law, rules and regulations. I warrant that all the information provided by me is true and accurate.
- I understand and agree that all information provided will be treated as confidential patient medical information and not released to any party other than the NM Dept. of Health as may be required.
- I understand the risk of using marijuana and agree to use it responsibly. I further fully release and indemnify New Mexicann Natural Medicine from any damages resulting from my use of and/or possession of marijuana, including criminal prosecution. I also understand and take full responsibility for any health hazard that may be caused by using cannabis.

Signature: _____ Date: _____

Please mail or fax this completed form along with clear photocopies of both your NM DOH Medical Cannabis ID and a photo I.D. (*either a NM Driver's License or U.S. Passport*). *If faxing your ID & DOH cards, please send in color, if that option is available on your fax machine.*

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I hereby authorize New MexiCann Natural Medicine to contact the New Mexico Department of Health and share any information regarding my registration to use and possess medical marijuana. This authorization allows both entities to share information, verbal and/or written, concerning the above named person or entity for the purpose of compliance with the Lynn and Erin Compassionate Use Act. I understand that neither party will disseminate any information learned by the other and that all shared information will be kept in the strictest of confidence by NewMexicann Natural Medicine and the executor of this document.

This authorization expressly permits New MexiCann Natural Medicine to share my confidential sales records and business activity with the New Mexico Department of Health at any time.

I understand that my authorization may be revoked by me, at any time, in writing. I also understand that revocation of my authorization could affect my right to purchase medical marijuana from New MexiCann Natural Medicine. I further understand that I have a right to know about any contact between New MexiCann Natural Medicine and the New Mexico Department of Health upon request.

A fax or scan copy of this authorization shall serve as the original.

Printed Name: _____

Signature: _____ *Date:* _____



New Mexicann Natural Medicine HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides rules and regulations as to who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service. A complete text of our HIPAA policy is available upon request. Additional information is available from the U.S. Department of Health and Human Services: www.hhs.gov.

New Mexicann HIPAA Policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. Patient files will be stored in locked cabinet files. The normal course of providing care means that such records will be located in administrative areas such as the front office. Those records will not be available to persons other than office staff as needed. You agree to the normal procedures utilized within the office for the handing of patient records, PHI and other documents of information.
2. NewMexiCann Natural Medicine utilizes a number of vendors in the conduct of business. These vendors may have access to PHI and must agree to abide by the confidentiality rules of HIPAA.
3. We may send you communications informing you of changes to office policies and new products and services that you may find valuable and informative. We may do this by telephone, email, U.S. Mail or by any means convenient for the office and/or as requested by you.
4. You agree to bring any concern or complaints regarding privacy to the attention of the delivery manager or the Director of Operations.
5. Your confidential information will not be used for the purposes of marketing or advertising of third party products, goods or services.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete or modify any of the provisions to better serve the needs of both the patient and the office, and inform you accordingly.
8. You have the right to withdraw consent in writing at any time; however, you will not be able to do business with New Mexicann Natural Medicine without signed consent.
- 9.

I, _____ on this day (date) _____ do hereby consent to and acknowledge my agreement with the terms set forth in the NewMexiCann Natural Medicine HIPAA Information and Consent Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.