Patient Registration Form

Green Rose Organics

11870 Santa Monica Blvd Ste 106 #578, Los Angeles CA 90025

___ Patient ___ Caregiver ___Renewal

First Name: _____ M: ___ Last: _____

California Drivers License/ID #: _____

Address: _____

City: _____ State: _____ Zip: _____

May the collective send you specials/discounts via Text?___
Phone Number: _____
May the collective send specials/discounts via email?___
Email Address: _____

Doctor Name: _____
Doctor License #_____
Doctor Phone #: _____
Last Visit Date: _____
Recommendation Expires: _____

Your Recommendation ID #_____

Green Rose Organics

I understand and agree as follows:

I am a qualified patient protected by California Health and Safety Code 11362.7. et. seg., and Senate Bill 420. My doctor has recommended the use of medical marijuana and provided written documentation of such recommendation. My doctor will review my case on a yearly basis. Per the relevant sections of California law, I am able to legally possess, use, and cultivate cannabis collectively for medical purposes. I designate **Green Rose Organics** as my care providers. I agree to follow all the rules and guidelines of the collective and pay reasonable compensation and/or volunteer for other services and activities provided by the collective.

I hereby authorize my treating doctor to release medical information regarding my diagnosis and condition to **Green Rose Organics**.

Signed: _____ Date:_____

For Office Use Only

Date and Time Verified: _____

Verified by:_____

Notes: _____

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