STATE OF HAWAII

DEPARTMENT OF HEALTH
4348 Waialae Avenue, #648
Honolulu, Hawaii 96816

Application # _____

329 Patient Certification - Adult

SECTION A. *This section must be signed by the qualifying patient.*

*Note: Please use your name **EXACTLY** as it appears on your **VALID** government-issued identification.*

Patient's Name _____
Last First Middle Suffix

I would like to designate a primary caregiver:

❍ No ❍ Yes *[If Yes, complete below and primary caregiver shall complete Section D.]*

My primary caregiver for the medical use of cannabis is: _____

Patient Statement of Understanding and Certification

❑ **Yes. I certify** that:

1) I have read, understand, and agree to comply with chapter 329, part IX, Hawaii Revised Statutes (HRS): Medical Use of Cannabis;
2) I have been diagnosed with the medical condition(s) as certified by my medical provider and as stated in this application;
3) My use of cannabis is solely for the treatment of my certified medical condition(s) included in this application;
4) I agree to abide by the conditions of use as provided in part IX, section 329-122, HRS, as well as ALL other sections of chapter 329, part IX, HRS.

Consent to Release Information

❑ **Yes**. **I consent** to allow my medical provider, so named in this application, to release any protected health information pertaining to my debilitating medical condition(s) for the purpose of my registration for medical use of cannabis as set forth in chapter 329, part IX, HRS, to authorized agents of the Department of Health.

This consent is valid for the duration of my medical use of cannabis registration card or until my written revocation of this consent. I understand that if I revoke my consent, my medical use of cannabis registration card will be revoked.

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this application. By signing this document, I acknowledge that I am subject to chapter 329, part IX, HRS, chapter 11-160, Hawaii Administrative Rules (HAR), and all other applicable laws for the medical use of cannabis in the State of Hawaii. I understand that my registration as a qualified patient to use medical cannabis under Hawaii law may not protect me against arrest, prosecution, or conviction under federal law.

_____ _____
Patient Signature Date