THE AUTISM & COMPASSIONATE CARE CONNECTION
PATIENT MEMBER TERMS AND CONDITIONS:

You are advised to research marijuana as medicine, and consult with your doctor as to dosage and frequency of medication. You are responsible for following these guidelines. You are responsible to use not abuse medicine. If we have any indication you are abusing medicine we will refuse service.

AS A CONDITION OF JOINING THE COLLECTIVE AND ENTERING OUR FACILITY, AND/OR BY UTILIZING SUCH MEDICINE/HERBAL MARIJUANA AND RELATED PRODUCTS AS YOU MAY OBTAIN, YOU, YOUR HEIRS AND THOSE WITH YOU EXPRESSLY AND FOREVER DISCLAIM THE WARRANTY OF MERCHANTABILITY AND THE WARRANTY OF FITNESS FOR PARTICULAR PURPOSE.

Any product obtained at our facility may be inspected prior to delivery, however since medical purity so requires, all transactions are final. The marijuana and related products are offered solely on an AS IS basis with no warranty whatsoever.

Patient understands that cannabis/marijuana may impair a person's ability to drive a vehicle or operate machinery.

Patient understands that loitering on or around a dispensary is prohibited by Cal. Penal Code section 647(e).

Diversion of Marijuana for Non Medical purposes is a violation of state law.

Please leave your friends, even fellow patients, at home, and NEVER in your car waiting for you.

Any member of law enforcement who is a bona fide patient must disclose the fact that he/she is a member of law enforcement. Otherwise, by entering these premises, you promise, state and affirm, under penalty of perjury under the laws of the State of California, that you are not a member of, affiliated with, nor employed by any law enforcement department, entity, or agency.

Management reserves the right to refuse service to anybody at any time for any reason or no reason whatsoever.

As a condition of entering our facility, and/or by utilizing such medicine/herbal marijuana and related products as you may obtain, you, your heirs and those with you expressly and forever waive any and all claims now known, or discovered at any time in the future due to, related to or arising from your use of marijuana or any other product/herb/food/oil/concentrate you may obtain at our facility.

As a condition of entering our facility, and/or by utilizing such medicine/herbal marijuana and related products as you may obtain, you, your heirs and those with you expressly and forever release our dispensary, its owners, landlord, operators, managers, employees, agents, attorneys, growers, providers, wholesalers, officers, directors, members, from and against any and all lawsuits, alter-ego lawsuits, demands, charges or claims with reference to the strength, potency, purity, toxicity, appropriateness for your condition of any marijuana and related products you may obtain at our facility; further, that you knowingly waive the provisions of civil code section 1542 which states in pertinent part that "A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."

As a condition of entering our facility, and/or by utilizing such medicine/herbal marijuana and related products as you may obtain, you, your heirs and those with you expressly and forever waive any and all claims now known, or discovered at any time in the future due to, related to or arising from your storage or handling of marijuana or any other product/herb/food/oil/concentrate you may obtain at our facility. KEEP ALL MEDICINE FAR FAR AWAY FROM CHILDREN OR ANYONE ELSE, UNDER LOCK AND KEY. ANY DEVIATION FROM THIS RULE IS DONE AT THE SOLE RISK AND RESPONSIBILITY OF THE PATIENT.

You agree not to use the medical marijuana you obtain from this center for social or casual marijuana use, but only for the medical condition for which it was recommended by your doctor.

You agree that as a Patient Member of our Collective, to abide by these rules and regulations.

I have read and agree to the above rules and regulations.

1. I have been diagnosed with a serious illness for which cannabis provides relief and I have received a recommendation or approval from my licensed California physician to use cannabis.
2. I understand my contributions for medicine I may acquire from this Collective are used to ensure continued operation and that this transaction in no way constitutes commercial promotion.
3. The monies I pay are to help the Collective to continue to operate, to maintain employees and a location and the associated costs and expenses of providing its members with medicinal marijuana for their medical needs.
4. The collective may cultivate, obtain, transport and possess cannabis on my behalf.
5. I designate the collective as my provider for medical marijuana.
6. I authorize the collective to contact my physician, and I authorize my physician to verify my recommendation to the collective.
7. I agree that I consistently rely upon the collective as the exclusive source of my cannabis medicine.
8. This designation shall remain in effect for 12 months, until the expiration of my recommendation, or until I revoke my designation in writing by certified mail, return receipt requested, whichever comes first.

X_____ Date: _____

How did you hear about our collective?_____

_____

Can the collective send you info, specials, discounts, and the annual Patient Members ballot to your EMAIL? If so please provide your email address:

Please print slowly

Dated: _____ Signed: **X**_____

Print name: _____

Print email address (PRINT SLOWLY):

Date/Dr.Office Confirmation _____ by____

PATIENT MEMBER PROXY and BALLOT

THE AUTISM & COMPASSIONATE CARE CONNECTION,

A CALIFORNIA NON-PROFIT MUTUAL BENEFIT CORPORATION

I understand that the founding members, who are also board of director members, seek my proxy, in voting to democratically control the center. The founding members state that they have guaranteed the lease, obtained the lease, license, permit, and/or are responsible as to the sales tax obligations, landlord, etc. Therefore, the founding members have extended benefits to me as a member and in exchange therefore I grant an irrevocable proxy to the board to vote on my behalf as a patient member pursuant to the bylaws of the corporation.

I submit the following as an annual advisory ballot.

My condition is: _____

My preferred strains are: _____

I think the pricing should be: _____

I would prefer the following hours of operation: _____

I would like to become more involved in the patient community as part of the phone tree _____ (y/n)

I would like to become more involved in the patient community as a candidate for advisory director of the nonprofit corporation. _____

I have the following additional comments for the board of directors:

_____

_____

_____

_____, Patient Member Dated _____

Printed Name:

PRINT EMAIL REALLY SLOWLY

_____

MEDICAL MARIJUANA HIPAA WAIVER HEALTH INFORMATION PRIVACY

I am aware of my right to privacy of my health related information. I hereby authorize the use and disclosure of the medical information contained in the medical recommendation of my physician for medical marijuana, for confirmation with the doctor by the center, from time to time. I also understand a copy of my record will be kept by the center on file. I understand that the center's policy on privacy is to not disclose the name or identity of any patient other than in the course of confirmation of the recommendation. I understand that I may have extra protection under California and Federal law as to my information however I expressly authorize the use and storage of this information in accordance herewith. I understand I may revoke my authorization in writing at any time and that the center will then maintain a record, but block out my name. I understand I am under no obligation to sign this form, however I realize that in order to ask the center to provide me access to medical marijuana, and at my own special request and instance, I grant the right to use the information as described herein. I understand I have a right to inspect or copy this authorization, and my file with the center. I understand that there is the possibility of redisclosure of information in the course of confirming my recommendation. This authorization shall terminate on the termination of my medical recommendation unless terminated sooner in writing by me. I have had an opportunity to review this form, I confirm it accurately reflects my wishes.

Date:_____

_____

Signed

_____

Print name

_____

Signature of Parent or guardian if patient is a minor or unable to sign