Hold Harmless Agreement

DISCLAIMER - GENERAL RELEASE, INDEMNIFICATION AND HOLD HARMLESS CLAUSE:

I,_____ , being of lawful age and sound mind do now release, acquit, and forever discharge Compassion Care from all actions, claims, demands, or damages sustained by or to me resulting from use or misuse of medical cannabis products exchanged among patients within the collective as effectuated by Compassion Care. This release shall remain in force and run concurrently with my membership in Compassion Care.

I have executed this release in _____, CA.

I further agree to indemnity and hold harmless Compassion Care from any injuries or damages resulting from use or misuse of medical edibles containing cannabis.

Signed: _____ Date: _____

Authorization for Release of Health Care Information to Compassion Care Under HIPAA & California Law

I,_____ , grant to Compassion Care, 3741 W. Shaw Ave., #1063, Fresno, CA 93711, my agent the authority to receive information regarding my health care needs, and to advocate for my health care needs, except as may be limited by my advance health care directive (if any), even if I have not been determined to lack capacity.

This release shall apply to any of my information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC §1320d and 45CFR pts 160, 164, and California law. I intend my agent to be dealt with by all my health care providers, as required by HIPAA and California law, in the exact same way as I would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

Pursuant to HIPAA and California law, I authorize any covered entity, including, but not limited to, any physician, health care professional, dentist, health plan, hospital, nursing home, clinic, laboratory, pharmacy, or any other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking to be paid for services, to give, disclose, and release to my agent and successor agent(s) named above, without restriction and at the request of my agent and successor agent(s), all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including, but not limited to, any and all DNA and/or genetic information, information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness (including information contained in mental health records protected by the Lanterman-Petris-Short Act), HIV/AIDS, and drug or alcohol abuse.

Any agent named herein shall be treated as my "legal representative," under California Civil Code §56.11(c)(2) for purposes of authorizing disclosure of medical information, and as my "health care agent" for purposes of the California Probate Code, including but not limited to §§4678, 4732, and 4733.

I may revoke this authorization at any time by written notice to the covered entity.

This authorization shall expire on the date of my death unless validly revoked prior to that date.

The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign an authorization unless the law allows conditions.

Under California law, all recipients of protected health care information may not redisclose it except as required or permitted by law.

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HlPAA regulations.

This authority shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information.

I have a right to a copy of this authorization.

Date: _____

_____
Principal Name (Printed)

_____
Signature of Principal

Membership Agreement

As a qualified patient protected by the California Law, Health & Safety Code Sections 11362.5 and 11362.7, et seq. and in conjunction with California Senate Bill 420, you are required to read and agree to the following statements to become a member of Compassion Care.

I Hereby certify that I am a patient suffering from a serious medical condition(s) and have obtained a written recommendation and/or approval from a licensed medical physician (that is my primary care physician and qualified to practice in the state of California) to use marijuana (medical cannabis) to treat my medical condition(s) (a "Qualified Patient"). My primary care physician 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. As a Qualified Patient under California law, I choose to associate collectively or cooperatively with Compassion Care to cultivate cannabis for my own medical purpose(s).

Members of the Compassion Care will contribute their labor, monetary funds, materials and/or a combination thereof, in exchange for medical cannabis.

Please read and understand the following statements:

1. I hereby declare under penalty of perjury under the laws of the state of California that a medical doctor has recommended or approved the use of medical cannabis as my medical treatment and that I have been diagnosed with a serious illness for which medical cannabis may provide relief.

Initials: _____

2. I further authorize Compassion Care to create and/or assign agency rights in its own name for the purpose of growing medical cannabis and/or obtaining edible forms of medical cannabis for my own personal benefit.

Initials: _____

3. I also agree to account for and provide evidence of all personal out-of-pocket expenses and reasonable compensation for my member services with Compassion Care.

Initials: _____

4. I hereby declare that I am a resident of the state of California and that my personal use of medical cannabis shall not, by any means, be transported outside the state of California. Furthermore, I certify and agree that any medical cannabis product which shall be provided to me by Compassion Care shall not be shared, sold, bartered, traded, exchanged and/or delivered, or by any other means thereof, be transported to a third party.

Initials: _____

5. I hereby declare and understand that my contributions to Compassion Care for and through prescribed medical products which I may acquire from Compassion Care are to be used to ensure the continued operation of Compassion Care and that any associated transactions in no way shall constitute a commercial promotion and/or sale of cannabis.

Initials: _____

6. I hereby declare and understand if I provide goods and/or services to Compassion Care, including, but not limited to, medical marijuana or any derivative thereof, cultivation efforts or equipment, I shall not request monetary payment or medical marijuana (or any other form of consideration) in excess of the actual cost of cultivating such marijuana, and I will ensure that nobody in my supply chain receives a profit. I agree to maintain financial records that reflect my actual costs (including contributions of labor, resources, or money) and to ensure the records are reasonably available.

Initials: _____

7. As a member of Compassion Care, I hereby agree to appoint and designate Compassion Care and its representatives as my true and lawful agents for the limited purpose of assisting me in obtaining medical cannabis for my own personal use, as legally prescribed by my primary medical care physician. As such, I understand that this may require Compassion Care to purchase, possess, transport, and/or distribute medical cannabis for and on my behalf; I hereby grant Compassion Care the limited authority to take such actions for and on my behalf. I further authorize Compassion Care to share my primary caregiver status with third parties in order for it to enter into contracts to obtain and/or allow growth/preparation of medical cannabis and edibles derived from cannabis for my own personal benefit.

Initials: _____

8. I agree not to provide goods or services to more than one collective, or otherwise divert medical marijuana for non-medical use. IF I AM FOUND TO BE PROVIDING GOODS OR SERVICES TO MORE THAN ONE COLLECTIVE, MY MEMBERSHIP SHALL BE IMMEDIATELY REVOKED.

Initials: _____

9. As a member of Compassion Care, I understand that Compassion Care may have other members with similar Membership Agreements. I hereby authorize Compassion Care to jointly possess any medical cannabis pursuant to this agreement jointly with other members of Compassion Care and/or individuals with similar agreement(s). I agree that any medical cannabis possessed by Compassion Care at any times is deemed the collective property of all patients who are members of Compassion Care and under the care of Compassion Care.

Initials: _____

10. I agree to provide Compassion Care with all changes in my contact information, diagnosis, and/or primary physician immediately.

Initials: _____

I understand that Compassion Care reserves the right to refuse service(s) to any member.

I affirm that I am above eighteen (18) years of age. I understand that my contributions to Compassion Care through products I may acquire from the organization will be used to ensure the continued operation of Compassion Care and that this transaction, in no way, constitutes a commercial promotion.

I understand that medical cannabis, while being a well-known effective therapeutic agent, is still deemed illegal by the federal government of the United States.

I hereby affirm that I agree to the terms of this Compassion Care Membership Agreement.

PATIENT MEMBER

Name (Print): _____

Rec. ID#: _____

Issue Date: _____

_____

Patient Signature

PRIMARY CAREGIVER (ONLY)

Name (Print): _____

Relationship to Patient: _____

_____

Primary Caregiver Signature

Patient Registration Form
Collective Membership

_____ Patient _____ Caregiver _____ Renewal

First Name: _____ M.I.: _____ Last: _____

California Driver License or ID Card #: _____

Date of Birth: _____ Patient ID#: _____

Address: _____City: _____ State:_____ Zip: _____

Phone: _____Cell: _____

Fax: _____Email:_____

Doctor's Organization: _____

Doctor's Name: _____

Doctor's Address: _____City: _____

Doctor's Phone Number: _____Verification Website: _____

Last Visit Date: _____Recommendation Expires: _____

Are you a member of more than one collective? Y or N (Circle One)
If yes, please explain why. (Check all that apply.)
_____ I changed my address
_____ I could not find the medicine I was looking for
_____ Convenience
_____ Other (explain) _____

I hereby authorize my treating doctor to release medical information regarding my recommendation information to Compassion Care.

_____ _____

Signed: Date: