HIPAA ACKNOWLEDGEMENT

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PRINTED PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

WE AT SHOW ME MEDICAL MARIJUANA, LLC, ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF AND PROVIDE INDIVIDUALS WITH THE NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION, "PHI." IF YOU HAVE ANY OBJECTIONS TO THE NOTICE, PLEASE ASK TO SPEAK WITH OUR HIPAA COMPLIANCE OFFICER BY PHONE AT OUR MAIN PHONE NUMBER OR BY EMAIL. IF YOU WOULD LIKE A COPY OF THIS NOTICE, PLEASE ASK.

I HEREBY ACKNOWLEDGE THAT I HAVE REVIEWED THE HIPAA NOTICE OF PRIVACY PRACTICE DOCUMENT.

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE

_____

PRINTED NAME OF PATIENT OR PATIENT'S REPRESENTATIVE

_____

RELATIONSHIP TO PATIENT