Social Equity Program

Caregiver Authorization for Release of MMMP Information

www.michigan.gov/cra (517) 284-8599

Instructions

1. This form is used to verify your caregiver experience with the Michigan Medical Marijuana Program (MMMP).
2. Section A: enter the information requested on lines 1-8. Forms must be signed & notarized within 90 days from the date the form is received in our office or online. You may only request verification of your caregiver status and that you have 2 years cumulative experience as a registered caregiver during the time period of 2008 – 2017.
3. You may either upload or mail the completed form and a legible copy of your valid driver's license or State-issued personal identification card with photo.

Upload Form and Identification at: www.michigan.gov/CRAonline

Mail Form and Identification to: **Cannabis Regulatory Agency**
P.O. Box 30205
Lansing, MI 48909

Section A – Person Authorizing Release of Information

1. Legal First Name	2. Middle Initial	3. Legal Last Name 3b. Suffix (Jr., Sr., etc.)	4. Date of Birth

5a. Mailing Address	5b. Apartment/Suite/Lot #

6. City	7. State	8. Zip Code

Section B – Release for Disclosure of Information

I authorize the Michigan Department of Licensing and Regulatory Affairs (LARA), or its successor department, to release Michigan Medical Marijuana Program (MMMP) records in accordance with section A, which may include caregiver identifying information, for the sole purpose of verifying my caregiver status and/or the number of cumulative years I have as a registered caregiver, to the Social Equity Program of the Cannabis Regulatory Agency.

I represent that I have provided proper identification to the notary public upon signing this form. Proper identification consists of a valid driver's license and/or State-issued personal identification card with photo. If I do not possess one of the named forms of identification, I represent that I provided a copy of my birth certificate *and* social security card to the notary public for purposes of identification.

I, my successors, heirs, assigns, and any other persons or entities who could lawfully make a claim on my behalf, release and hold harmless LARA, or its successor department, including but not limited to each of its divisions, agencies, commissions, officers, and employees, and the successors, heirs, and assigns of such persons and entities, from any and all rights, actions, grievances, claims, liabilities, demands, suits, and causes of action, based on any grounds for relief, whether in law or equity, under state or federal law, of each kind, nature, and description, whether known or unknown, suspected or unsuspected, that either may have, now or in the future, against the above listed entities and persons as a result of or arising out of the disclosure by LARA, or its successor department, of the requested information and/or documents.

I represent and warrant that, based upon a reasonably diligent inquiry and the advice of counsel, if any, I have legal authority to sign this form, and that I bear sole responsibility for any mistake regarding my legal authority to sign this form. I further represent and warrant that I have either reviewed or had the opportunity to review the Michigan Medical Marihuana Act, MCL 333.26421 *et seq.,* and associated administrative rules, which are available on the MMMP's website or upon request to the MMMP.

I understand that if any portion of this form is not completed in accordance with the instructions, this request for the MMMP records will be DENIED.

Section C – Your Signature

I represent and acknowledge that I have read, understand, and agree with Section B, regarding my request for release of my caregiver status, number years of cumulative experience that I have been a registered caregiver with the MMMP, or both.

____
PRINT NAME of Person Authorizing Release

____ ____________________________
Signature of Person Authorizing Release Date

THIS SECTION MUST BE NOTARIZED WITH PROPER IDENTIFICATION (AS DESCRIBED IN SECTION C) PROVIDED TO A NOTARY PUBLIC

Subscribed and sworn before me this
_____________day of ________, 20____

____________________________Notary _______________County, State

of _____

My commission expires______________