# Account Verification Release Form

I, _____, hereby give my consent to the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Medical Cannabis, or its duly authorized agents, to obtain financial information on any of the following accounts associated with _____ (name of individual applicant or business entity) from:

| Financial Institution Name | Financial Institution Address | Account # |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

_____

Print Name

_____

Signature of Authorized Account Holder Date

State of _____

County of _____

This record was acknowledged before me on _____by_____

_____

Notary Public

My commission expires _____

Place Stamp Here

A photocopy, facsimile, or other electronic version of this document may be accepted as an original signature.