WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH
Office of Medical Cannabis

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	Street Address, Phone and Fax Numbers (a fax number or mailing address for account verification is REQUIRED)	Account Number

_____ _____

Printed Name of Authorized Account Holder 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

Ver 06232020

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