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CAREGIVER FORM

To be completed by the patient and the caregiver responsible for the patient

1 CAREGIVER INFORMATION

☐ Male ☐ Female

Patient's ID Number: _____

Caregiver's First Name _____

Caregiver's Last Name _____

Caregiver's D.O.B (MM/DD/YYYY) _____

Primary Phone Number _____

Email _____

Can we leave detailed voicemails? ☐ Yes ☐ No

2 SIGNATURE

I, _____ (Full Name of Caregiver) _____ (Relationship to Patient (as required)), am the responsible caregiver for _____ (Name of Patient)

By signing this Caregiver Form:

1. By signing this Caregiver Form, you acknowledge that Tilray Medical is a medical marketplace brand of Aphria Inc, which is a federally authorized 'Sale for Medical Purposes' licence holder. As such, you acknowledge that Aphria Inc is responsible for completing all registrations and transactions through Tilray Medical and with whom you will be registered.

2. By signing you consent to Tilray Medical's collection use and disclosure of the personal information contained in it and in all related documents, such as any medical document or registration certificate, in accordance with Tilray Medical's External Privacy Policy available at: www.tilray.com/general-privacy-policy. This includes, without limitation, disclosure of any and all patient personal information collected by Tilray Medical to the patient's Caregiver and disclosure of any and all caregiver personal information to the patient. Hard copies of the External Privacy Policy are available upon request. If the personal information in the Caregiver Form pertains to someone other than you, you represent and warrant that you have obtained their consent and/or have authority to consent on their behalf. Consent may be withdrawn at any time but such withdrawal will not have retroactive effect. NOTE: This may have implications to you and/or the subject individual and will not affect the collection, use and disclosure of personal information where such collection, use and disclosure is permitted or required by law without consent.

3. As the patient, you authorize the responsible individual/caregiver to act on your behalf with respect to anything you could do on your behalf with Tilray Medical and you authorize Tilray Medical to accept such authority.

Patient Signature: _____

Caregiver Signature: _____

Date (MM/DD/YYYY): _____