COLORADO
Medical Marijuana Registry
Department of Public Health & Environment

SR

Provider Signature Revocation

This form must be submitted with a copy of your Colorado driver's license or photo ID.

STAFF ONLY

_____
Evaluated

By submitting this form, your name and contact information will be removed from the patient's current record. Patients are notified when a signature has been revoked and given the opportunity to secure a new provider.

Please submit this form by email to medical.marijuana@state.co.us.

Processing time:
Please allow 3-5 weeks from the date the Registry receives your paperwork for standard processing.

I am revoking my signature as a:	
☐ Caregiver	☐ Physician (Physician License # _____)

Patient Information		
1. Last Name	2. First Name	3. Date of Birth

Provider Information			
4. Last Name	5. First Name		
6. Middle Initial	7. Date of Birth		
8a. Mailing Address			8b. Apt/Ste
9. City		10. State	11. Zip Code
12. Telephone	13. Email		

14. Please explain why you wish to revoke your signature from the patient's record:

_____
_____
_____
_____
_____
_____

I hereby certify that I no longer provide medical or care giving services to the above listed patient. I authorize the Medical Marijuana Registry to contact me using the telephone number and email address I have provided above. This includes leaving messages on the contact telephone number I have provided.	
15a. Provider's Signature:	15b. Signature Date