Colorado Department of Public Health and Environment

Medical Marijuana Registry

4300 Cherry Creek Drive South, Denver, CO 80246-1530 • 303-692-2184
E-mail: medical.marijuana@state.co.us • **Website:** www.cdphe.state.co.us/hs/medicalmarijuana

RP

Request for Patient Information

Instructions:

1. Complete all required sections of the form neatly and accurately.
2. **There are no fees to file this form.**
3. **Do not write-over, cross-out, or use white-out on this form, or it will be voided**. If you make a mistake on the form, please complete a new one.
4. After completing the form, you must sign and date it in front of a notary and have it notarized.
5. **Include a copy of your valid Colorado ID.** The chart below lists the documents the Registry will accept:

PROOF OF IDENTITY	
The Registry requires a verifiable, photo ID for all forms. Please submit one of the following IDs with your form:	
• Colorado Driver's License • Colorado photo ID • Temporary Colorado Driver's License • Temporary Colorado ID	• Out-of-state Driver's License • Out-of-state photo ID • U.S. Passport • Military ID (copy of front and back) • Tribal ID
i. All documents must be currently valid when received at the Registry. ii. Damaged, expired, or tampered IDs are not valid. iii. The address on the photo ID **does not** have to match the mailing address on the form. iv. All IDs must be verifiable and have specific issue and expiration dates. v. The ID must show the patient's date of birth.	

6. Patient social security numbers are used to confirm identity and protect confidentiality.
7. Incomplete forms will be voided and returned to you. A form is considered complete when:
   a. The form is completed, signed and notarized.
   b. A copy of the patient's photo ID is included.
   c. A copy of the caregiver's ID must be included, if the form has caregiver information.
8. Forms must be sent separately, one form per envelope.
9. Make a copy of all your paperwork for your files.
10. Unless a fee is required, DO NOT send money to the Registry. All monies received at the Registry are nonrefundable.
11. You must submit paperwork within **ten (10) days** of the date you have it notarized.
12. **Please allow 4 weeks** from the date the Registry receives your paperwork for processing**.** If you have not received a response within 4 weeks, please contact the Registry at 303-692-2184. Your paperwork or card will be mailed to the address on your form.
13. Submit paperwork by mail or deliver to the Registry's drop-box. **The Registry does not accept forms by fax or e-mail.**

Mail to:

Customer Service Unit
CDPHE
HSV-8608
4300 Cherry Creek Drive South
Denver, CO 80246-1530

Drop-Box:
Colorado Dept. of Public Health & Environment
710 S. Ash Street, South East Entrance
Open: Monday-Friday, 7:00 a.m. to 6:00 p.m.
The drop box is on the wall inside the first set of glass doors. Your paperwork must be in a sealed envelope. You will not receive a receipt. **If you wish to have a receipt, please mail in your paperwork by certified mail.**

For more information, visit our website www.cdphe.state.co.us/hs/medicalmarijuana or call 303-692-2184.

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STAFF ONLY

CSU

Corrections:

Request for Patient Information

This form is not valid as a temporary registry card

See instructions on page 1. Photo ID required with all forms.

1. Social Security Number (optional)	**Section A: Patient Information (Required)** **The name on the form must match the legal name on your photo ID.**			
2. Last Name	3. First Name			4. Middle Initial
5a. Mailing Address		5b. Apartment/Suite #	6. City	
State **CO**	7. Zip Code	8. County	9. Date of Birth	10. Telephone Number
11. E-mail Address (optional)*				12. Gender ☐ Male ☐Female

* By providing your e-mail address, you agree to receive communication from the Registry by e-mail.

13. Please describe the types of information for which you wish to receive copies.

_____

_____

_____

_____

_____

14. Confirm request. Please check the box below to confirm your request and potential expenses.

☐ By signing this document, I am requesting copies of the above-mentioned information from my patient records. I understand that the first 10 pages are copied for free. If there are more than 10 pages in my record, the Registry will not make copies until they notify me of the cost. I may decide at that time, if I want the additional pages copied.

I hereby certify that the above information is correct and complete.	
15. Applicant's Signature: ▶	16. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me by _____ in _____ County, Colorado
(Name of patient printed by notary) (County name)

on this _____ day of _____, 20____.
(Day) (Month)

_____
(Notary's official signature)

_____
(Commission expiration date) AFFIX NOTARY SEAL