COLORADO
Medical Marijuana Registry
Department of Public Health & Environment

SR

Provider Signature Revocation

This for 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 Patients are notified when a signature has been revoked and given the opportunity to secure a new provider.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	
15a. Provider's Signature:	15b. Signature Date