



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 Patients are notified when a signature has been revoked and given the opportunity to secure a new provider.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:	
<input type="checkbox"/> Caregiver	<input type="checkbox"/> 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 CO	11. Zip Code
12. Telephone	13. Email	

By checking this box , I authorize the Medical Marijuana Registry to contact me using the telephone number and email address above. This includes leaving voicemail messages on the contact telephone number.

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