



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 Patients are notified when a signature has been revoked and given the opportunity to secure a new provider.

Submit paperwork by mail or deliver to the Registry's drop-box:

Mail: Application Processing, CDPHE, HSV-8608, 4300 Cherry Creek Dr S, Denver, CO 80246-1530

Deliver to drop-box: 710 S Ash St, southeast entrance, 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.

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	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