



# Medical Marijuana Registry

4300 Cherry Creek Drive South, Denver, CO 80246-1530 • 303-692-2184

E-mail: [medical.marijuana@state.co.us](mailto:medical.marijuana@state.co.us) • Website: [www.cdphe.state.co.us/hs/medicalmarijuana](http://www.cdphe.state.co.us/hs/medicalmarijuana)

## Change of Patient Records Instructions

### Instructions:

1. Complete all required sections of the form neatly and accurately.
2. **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.
3. After completing the form, you must sign and date it in front of a notary and have it notarized.
4. Include a copy of your valid Colorado ID. If you do not have a valid Colorado ID, you will need to submit a photo ID and proof of residency. The chart below lists the documents the Registry will accept as proof of identity and residency.

PROOF OF IDENTITY AND COLORADO RESIDENCY	
<p><b>One (1) of the following:</b></p> <ul style="list-style-type: none"> <li>• Colorado Driver's License</li> <li>• Colorado ID</li> <li>• Temporary Colorado Driver's License</li> <li>• Temporary Colorado ID</li> </ul>	<p><b>Or two (2) of the following:</b></p> <p><b>Minimum of one (1) from the group of IDs below -</b></p> <ul style="list-style-type: none"> <li>• Out of State Driver's License</li> <li>• Out of State ID</li> <li>• Passport, Military ID (copy of front and back), Tribal ID</li> </ul> <p><b>And a minimum of one (1) from the group below -</b></p> <ul style="list-style-type: none"> <li>• Proof of Colorado Employment (paycheck stub/W-2)</li> <li>• Copy of a utility, medical, or cable bill. (The mailing address on all bills must match address on application. For utility and cable bills, the service address must be in Colorado.)</li> </ul>
<p>i. All documents must be currently valid when received at the Registry. Damaged, expired, or tampered IDs are not valid.</p> <p>ii. Proof of residency materials must be current, within 60 days of the date the Registry receives your paperwork.</p> <p>iii. At least one (1) of these documents must show the patient's date of birth.</p>	

5. You may **only** change your caregiver or Medical Marijuana Center one time per month.
6. 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 Colorado photo ID **or** an out-of-state ID and proof of Colorado residency is included.
  - c. A copy of the caregiver's ID must be included, if the form has caregiver information.
7. Forms must be sent separately, one form per envelope.
8. Make a copy of all your paperwork. Keep the copy for your files. Submit your originals to the Registry.
9. You must submit paperwork within **ten (10) days** of the date you have it notarized.
10. **The Registry only prints new cards for patients who are homebound or have submitted a change of name.**
11. 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:

Colorado Dept. of Public Health & Environment  
 HSV-MMR  
 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](http://www.cdphe.state.co.us/hs/medicalmarijuana) or call 303-692-2184.



Colorado Department  
of Public Health  
and Environment

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## Change of Patient Records

**STAFF ONLY**

Homebound  
 Yes  No

EPU Approval  
 Yes  No

QA Approval  
 Yes  No

Card Printed  
 Yes  No

Corrections:

<b>Patient Information (Required)</b>						1. Social Security Number - -	
<b>The name on the form must match the legal name on your photo ID.</b>							
2. Last Name			3. First Name			4. Middle Initial	
5. Mailing Address (including Apartment or Suite #)						6. City	
State <b>CO</b>	7. Zip Code	8. County	9. Date of Birth / /		10. Telephone Number ( ) -		
11. E-mail Address (optional)*						12. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
* By providing your e-mail address, you agree to receive communication from the Registry by e-mail.							
<b>Change Request: Please mark all changes that apply. For each option selected, complete all blanks.</b>							
<input type="checkbox"/> 13. <b>Change my contact information.</b> The above address and contact information is new.							
<input type="checkbox"/> 14. <b>Change my name.</b> I have enclosed a copy of the certified, official document that proves my name change.							
Old Name		a. Last Name		b. First Name		c. Middle Initial	
New Name		d. Last Name		e. First Name		f. Middle Initial	
Support Documentation		g. I have included a copy of the following certified document to prove my name change: <input type="checkbox"/> Marriage Certificate <input type="checkbox"/> Divorce Decree <input type="checkbox"/> Other court documents					
<input type="checkbox"/> 15. <b>Caregiver as "Self."</b> Please remove the Medical Marijuana Center and/or Caregiver from my records.							
<input type="checkbox"/> 16. <b>Change my Medical Marijuana Center (MMC).</b> Only homebound patients, or patients under age 18, may list both a caregiver and a Medical Marijuana Center.							
Medical Marijuana Center Information		a. Name of Medical Marijuana Center					
		b. Mailing Address of the Medical Marijuana Center (including Apartment or Suite #)					
		c. City	d. State <b>CO</b>	e. Zip Code	f. Telephone Number ( ) -		
<input type="checkbox"/> 17. <b>Change of caregiver.</b> Please change my caregiver to the individual listed below. I have enclosed a copy of the caregiver's valid ID. The name on this form must match the name on the ID. Only homebound patients, or patients under age 18, may list both a caregiver and a Medical Marijuana Center.							
Caregiver Information		a. Caregiver's Last Name		b. Caregiver's First Name		c. Middle Initial	
		d. Caregiver's Mailing Address (including Apartment or Suite #)					
		e. City	f. State	g. Zip Code	h. Date of Birth / /	i. Telephone Number ( ) -	
<b>I hereby certify that the above information is correct and complete.</b>							
18. Applicant's Signature: 						19. 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 applicant printed by notary) (County name)

on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.  
(Day) (Month)

\_\_\_\_\_  
(Notary's official signature)

\_\_\_\_\_  
(Commission expiration date)

AFFIX NOTARY SEAL