



# Medical Marijuana Registry

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

Email: [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)

## Request for Patient Information

### 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. 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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This form is not valid as a temporary registry card

<b>STAFF ONLY</b>  <b>CSU Approval</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Section A: Patient Information</b> <b>The name on the form must match the legal name on your photo ID.</b>				1. Social Security Number - -
	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>Corrections:</b>	<b>13. Please describe the types of information for which you wish to receive copies.</b> <hr/> <hr/> <hr/> <hr/> <hr/>				
	<b>14. Confirm request.</b> Please check the box below to confirm your request and potential expenses. <input type="checkbox"/> 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.				
<b>I hereby certify that the above information is correct and complete.</b>					
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 <small>(Name of applicant printed by notary) (County name)</small> on this _____ day of _____, 20____. <small>(Day) (Month)</small> _____ <small>(Notary's official signature)</small> _____ <small>(Commission expiration date)</small>					
				AFFIX NOTARY SEAL	