MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR MEDICAL MARIJUANA REGULATION
MEDICAL MARIJUANA REGULATORY PROGRAM

PATIENT AUTHORIZATION FORM

A Patient Authorization Form is required by 19 CSR 30-95.030 as proof of a patient's desire that a particular individual serve as the patient's primary caregiver and must be submitted with a Primary Caregiver Registration Application. Please ensure information provided is consistent with the applicable Primary Caregiver Registration Application.

PATIENT NAME

LAST NAME	FIRST NAME	MIDDLE NAME

PRIMARY CAREGIVER NAME

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH

I, _____, affirm that it is my desire that _____, serve as my primary caregiver in order to assist me in the medical use of marijuana.

PATIENT SIGNATURE	DATE

MO 580-3271 (6-19) DHSS-MMRP-4 (6-19)