MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF CANNABIS REGULATION

PATIENT AUTHORIZATION FORM

A Patient Authorization Form is required by 19 CSR 100-1.040(6)(A)3.G. as proof of a patient's desire that a particular individual serve as their primary caregiver. Information provided must match the information submitted in the Primary Caregiver application and associated Qualifying Patient record. **[1]**

QUALIFYING PATIENT INFORMATION [2]

LAST NAME	FIRST NAME	MIDDLE NAME

PAT # **[3]**

PRIMARY CAREGIVER INFORMATION [4]

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH

I, _____ **[5]** , the qualifying patient, authorize _____ **[6]** , to serve as my primary caregiver to assist in the purchase, possession, and administration of medical marijuana on my behalf. I understand that authorizing a primary caregiver is my right as a patient, and therefore it will always be my decision whether they will continue to be authorized for that purpose.

PATIENT SIGNATURE **[7]**	DATE **[7]**

INSTRUCTIONS

[1] This completed form must be submitted with a New or Renewal Primary Caregiver application in the online registry portal, within the document upload section labeled "Patient Authorization Form".

[2] Full name of the **patient** who is authorizing the applicant to serve as their primary caregiver.

[3] The state-issued ID card number assigned to the approved qualifying patient. Beginning with PAT, followed by a sequence of numbers. (Example: PAT######)

[4] Full name, social security number, and date of birth of the **caregiver** applicant who is being authorized to serve on behalf of the qualifying patient.

[5] Qualifying patient name

[6] Primary caregiver name

[7] Patient hand-written or electronic signature and date.