



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
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PAT # [3]

PRIMARY CAREGIVER INFORMATION [4]

LAST NAME	FIRST NAME	MIDDLE NAME
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SOCIAL SECURITY NUMBER	DATE OF BIRTH
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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]
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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.