



AUTHORIZATION TO CHANGE HEALTHCARE PROVIDER

Complete this form to allow the New Jersey Cannabis Regulatory Commission to switch your healthcare provider to another participating provider within the Medicinal Cannabis Program.

Patient Registry ID Number: _____ DOB: _____

Patient Address: _____

I, _____ (print name) authorize the NEW JERSEY CANNABIS REGULATORY COMMISSION to change my healthcare provider from _____ (current provider) to _____ (new provider), effective _____ (date).

I understand this consent is voluntary and that I may change healthcare providers at any time.

Patient Signature

Date

Please return authorization to:

New Jersey Cannabis Regulatory Commission
Attention: Medicinal Cannabis Program Patient Services
PO Box 216
Trenton, NJ 08625
medcannabis@crc.nj.gov