



**STATE OF HAWAII**  
**DEPARTMENT OF HEALTH**  
 4348 Waiialae Avenue, #648  
 Honolulu, Hawaii 96816



## Medical Marijuana Registry Program

In accordance with Hawaii Revised Statutes 329-123 (b) "Qualifying patients shall report changes in information within ten working days." This form may be used to provide the Department of Health with written notification that would VOID a registration card for the registered patient. This form must be signed by the registered patient or by the appropriate parent, guardian, or legal custodian, as applicable, if the registered patient is a minor or adult lacking legal capacity. If the program participant is deceased, this form must be signed by the physician or may be submitted by a family member with appropriate documentation (i.e. death certificate). NO FEE is required. **Incomplete Forms will be returned.**

### 329 Request to Void Patient's Registration Card

This Request to Void is for the 329 Registration Card #: \_\_\_\_\_

**Patient Name:** as it appears on the Registration Card

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

**REQUIRED** Supporting documentation:

- The 329 Registration Card referenced above (unless patient is deceased).
- A clear copy of the patient's valid ID that was used to register, clearly showing the patients name, photo, and expiration date of the ID.

**MARK ONE**

- Patient is deceased.** (If patient is deceased, physician must submit this form)
- Patient no longer has debilitating medical condition.**
- Patient is moving out of state.**
- Patient is no longer benefiting from the use of medical marijuana.**
- Other** \_\_\_\_\_

**Registered Patient Signature**

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information on this form. By signing this document I acknowledge that I am no longer protected under part IX, chapter 329, HRS, chapter 11-160, HAR, and all other applicable laws for the medical use of marijuana in the State of Hawaii. I further understand that the Department of Health may inform law enforcement agencies that I am not registered as a patient.

\_\_\_\_\_  
 Print Patient (or Legal Guardian) Name      Patient (or Legal Guardian) Signature      Date

**Physician Signature** *(only required if registered patient is deceased)*

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this form.

\_\_\_\_\_  
 Print Physician Name      Physician Signature      Date