



**STATE OF HAWAII
DEPARTMENT OF HEALTH
OMCCR – PATIENT REGISTRY**
4348 Waiālae Avenue, #648
Honolulu, Hawaii 96816



329 Caregiver Request to Revoke Authorization

To revoke your authorization to act as a caregiver for a qualifying patient you must:

Complete and return this form with the following supporting documents:

1. A copy of caregiver valid I.D. (driver’s license, state I.D., or passport)
2. A money order or cashiers check only for \$16.50 payable to the Department of Health

Revoking your authorization to act as a caregiver for a qualifying patient requires a duplicate replacement 329 registration card to be issued to the patient.

Please **mail** entire packet to:
Department of Health
4348 Waiālae Ave #648
Honolulu, Hawaii 96816

This REQUEST is for 329 Registration Card #: _____

Patient Name: as it appears on my current 329 Registration Card:

First Name: _____ Middle Name: _____ Last Name: _____

Current **Caregiver Name** as it appears on my current 329 Registration Card:

First Name: _____ Middle Name: _____ Last Name: _____

Are you currently the owner/controller of the Patients grow site location?

Yes, please list the grow site location the caregiver is registered to:

No

I certify the following:

- I hereby revoke my previous agreement to undertake responsibility for managing the well-being of the qualifying patient with respect to the medical use of cannabis.



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- I agree and acknowledge that by revoking my previous agreement to be the caregiver for the aforementioned qualifying patient, I will no longer be protected under part IX, chapter 329, Hawaii Revised Statutes (HRS), as was previously documented through the enclosed 329 Registration Card.
- I confirm that I have notified the patient, named above, that I am revoking my previous agreement to be their caregiver and if applicable, revoking as the registered caregiver who owns and controls the grow site for the qualifying patient.
- I confirm that I have returned to the qualifying patient or destroyed any cannabis plants or usable cannabis in my possession.
- I understand that the Department of Health will immediately invalidate my enclosed 329 Registration Card, and this action will not adversely impact the valid status of the qualifying patient’s 329 Registration Card.

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding. 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, and all other applicable laws for the medical use of cannabis 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 caregiver.

Print Caregiver Name

Caregiver Signature

Date