MDH Minnesota Department *of* Health

OFFICE OF MEDICAL CANNABIS

Medical Cannabis Patient Registry Information Request Form

(LAW ENFORCEMENT REQUEST)

Based on the attached search warrant, please provide information from the Minnesota Medical Cannabis Patient Registry relating to:

Name: _____ Date of birth (if known) _____

List known alias names: _____

Other information: _____

Requestor Information

Name (Please Print) _____

Agency Name: _____

Mailing Address: _____

City, State, Zip

_____ _____

Phone Number Email Address

Please submit this form along with a photocopy of the search warrant to:

Via mail:
Office of Medical Cannabis
PO Box 64882
St. Paul, MN 55164-0882

Via email:
health.cannabis@state.mn.us

Note: Requests will be processed within 2 business days.