

PATIENT PRESCRIPTION RECORD REQUEST

Instructions:

1. Provide the information requested below and return the signed request form with a copy of your current U.S. valid driver's license or other valid government issued photo identification.
2. If you are an authorized representative of the patient and you are requesting a copy of the patient's prescription report, please fill out the information below and attach documentation that demonstrates you have the legal authority to request and receive the report, and attach a photocopy of your current driver's license or other valid government issued photo identification.
3. Mail or e-mail the completed application to:
Pennsylvania Prescription Drug Monitoring Program Office
ATTN: Patient Record Request
 625 Forster Street
 9th Floor, RM 912
 Health and Welfare Building
 Harrisburg, PA 17120
 Email: RA-DH-PDMP@pa.gov

PATIENT INFORMATION			
First Name:	Middle Name:	Last Name:	Suffix: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr. <input type="checkbox"/> Other_____
Alternative First Name:	Middle Initial:	Maiden Name:	
Gender: <input type="checkbox"/> F <input type="checkbox"/> M	DOB: MM/DD/YYYY	Type of identification provided:	
CURRENT ADDRESS			
Street:	Apt/Unit:	PO Box:	
City:	State:	ZIP Code:	
Telephone:	Mobile:	E-mail:	
PREVIOUS ADDRESS			
Street:	Apt/Unit:	PO Box:	
City:	State:	ZIP Code:	
Previous Telephone:			
Prescriptions filled/dispensed from date: MM/DD/YYYY		Prescriptions filled/dispensed to date: MM/DD/YYYY	
AUTHORIZED REPRESENTATIVE <i>Parent/Guardian/Power of Attorney</i>			
Are you the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Note: If you are requesting this information for someone other than yourself please complete the information below and provide with a legal documentation proving your authorization.		
Relationship to the patient:			
First Name:	Middle Name:	Last Name:	Suffix: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr. <input type="checkbox"/> Other_____
DOB: MM/DD/YYYY		Type of Identification provided:	
Street:	Apt/Unit:	PO Box:	

City:		State:	ZIP Code:
Telephone:	Mobile:	E-mail:	

AGREEMENT

To my knowledge the information provided in this document is accurate. I understand that forms with unclear or incomplete information may not be processed. Unsigned forms will not be processed. I understand that I can request access to my prescription record at no cost once per calendar year quarter. If I request records more than once per quarter, the PA PDMP office will charge \$20 for processing.

Unlawful acts as identified in Act 191 of 2014 --

(1) A person commits a misdemeanor of the first degree if the person knowingly or intentionally obtains or attempts to obtain information from the system for purposes other than the authorized users as described in Act 191 or by misrepresentation or fraud.

By submitting this request, I authorize the PA PDMP to search and print my prescription record information.

Note: The prescription drug monitoring program did not begin collecting prescriptions of controlled substances Schedule II to V data until June 24, 2016 and all personal information will be destroyed after seven (7) years, so prescription history is limited to that timeframe.

Signature:

Date:

INTERNAL USE ONLY

Request Number:	Date Approved:	Date Mailed:
Date Received:	Previous requests:	
Received by:		

Comments/Notes: