pennsylvania
DEPARTMENT OF HEALTH
PRESCRIPTION DRUG MONITORING PROGRAM

Website: www.doh.pa.gov/PDMP
Phone: 844-377-7367 (844-377-PDMP) from M-F 8am to 4pm EST

PATIENT PRESCRIPTION RECORD REQUEST

Instructions:

1. Provide the information requested below and return the signed request form with a valid government issued photo identification (U.S. driver's license, state identification card, or passport). All asterisk (*) marked fields are required.

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
   6th Floor, RM 604
   Health and Welfare Building
   Harrisburg, PA 17120
   Email: RA-DH-PDMP@pa.gov

PATIENT INFORMATION			
*First Name:	Middle Name:	*Last Name:	Suffix: ❑ Sr. ❑ Jr. ❑Other____
Alternative First Name:	Middle Initial:	Maiden Name:	
*Gender: ❑ F ❑ M ❑ X	*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 *(Please use Page 3 to list all additional previous addresses).		
Street:	Apt/Unit:	PO Box:
City:	State:	ZIP Code:
Previous Telephone:		

***PRESCRIPTION HISTORY TIMEFRAME**	
*Prescriptions filled/dispensed from date: MM/DD/YYYY	*Prescriptions filled/dispensed to date: MM/DD/YYYY

AUTHORIZED REPRESENTATIVE ***Parent/Guardian/Power of Attorney***			
Are you the patient? ❑ Yes ❑ 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: ❑ Sr. ❑ Jr. ❑Other____
DOB: MM/DD/YYY		Type of Identification provided:	
Street:		Apt/Unit:	PO Box:
City:	State:	ZIP Code:	
Telephone:	Mobile:	E-mail:	

PDMP SYSTEM SEARCH HISTORY

Would you like to receive a listing of any searches for your PDMP prescription record?
❑ Yes ❑ No

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 dispensation record and search history at no cost once per calendar quarter. If I request records more than once per quarter, the PA PDMP Office will charge $20.00 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 dispensation information.

***Note**: The prescription drug monitoring program did not begin collecting prescriptions of Schedule II to V controlled substances until June 24, 2016. All personally identifiable information will be destroyed after seven (7) years, so prescription history is limited to that timeframe. Any administrative searches conducted by the commonwealth are excluded from the PDMP search history report. In the case where a law enforcement agency has accessed the system for an active investigation, the information about that query shall be withheld from the individual subject to the query for a period of six months after the conclusion of the investigation.*

*Signature:	*Date:

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PATIENT PRESCRIPTION RECORD REQUEST
Additional Previous Addresses

Instructions:

Please provide the information requested below for all previous addresses for which you are requesting prescription records.

PREVIOUS ADDRESS		
Street:	Apt/Unit:	PO Box:
City:	State:	ZIP Code:
Previous Telephone:		

PREVIOUS ADDRESS		
Street:	Apt/Unit:	PO Box:
City:	State:	ZIP Code:
Previous Telephone:		

PREVIOUS ADDRESS		
Street:	Apt/Unit:	PO Box:
City:	State:	ZIP Code:
Previous Telephone:		

PREVIOUS ADDRESS		
Street:	Apt/Unit:	PO Box:
City:	State:	ZIP Code:
Previous Telephone:		

PREVIOUS ADDRESS		
Street:	Apt/Unit:	PO Box:
City:	State:	ZIP Code:
Previous Telephone:		

PREVIOUS ADDRESS		
Street:	Apt/Unit:	PO Box:
City:	State:	ZIP Code:
Previous Telephone:		