



2829 University Ave SE, Suite 530 Minneapolis, MN 55414
Phone: 651/201-2836 Fax: 612/617-2261

www.pmp.pharmacy.state.mn.us

Individual's Controlled Substance Prescription History Report Request & Authorization of Release to a 3rd Party

An individual may request information relating to their personal controlled substance prescription history be sent to a third party by completing a request form and submitting it by mail, fax, or email to the MN PMP.

- **Request forms must be notarized. Forms that have not been signed in the presence of a Notary will be returned.**
- If the individual in the report is under the age of 18 years, a parent or guardian must request the report. In order to show proof of relationship, the following must also be submitted:
 - A certified copy of the individual's birth certificate (*showing the requesting parent's name*) or original, certified copy of court order granting legal guardianship.
(*All certified copies will be returned to the requester*)
- Individual must be informed of their rights (listed in Section 4). Person informing individual of rights must sign and date Section 3.
- Data is returned via secure email. If no email address listed, report will be sent via certified mail.
- Third Party recipient of data (Section 3) **must be** named an individual and not an agency or business.
- **Incomplete forms will be returned.**

Upon completion, please mail, fax, or email your request to:

MN Board of Pharmacy
Prescription Monitoring Program
2829 University Ave SE, Suite 530
Minneapolis, MN 55414

minnesota.pmp@state.mn.us

Fax: 612-617-2261

(Request will be processed with 10 business days of receipt)



Individual's Controlled Substance Prescription History Report Request
&
Authorization for Release Information to a 3rd Party

Section 1: Subject of the Data	Name (first, middle, last)	Date of Birth		
	Address	Phone Number		
	City	State	Zip Code	
Section 2: Release Information From:	Minnesota Prescription Monitoring Program Minnesota Board of Pharmacy, 2829 University Ave SE, Suite 530, Minneapolis, MN 55414			
Section 3: Release Information To:	Name	Agency (optional)		
	Address	City	State	Zip Code
	Phone Number	Email Address		
	Mailing Address (if Different From Above)			
	City	State	Zip Code	
	Purpose of Use:			
	Signature of Person Informing of Rights:	Date:		
Section 4: Explanation of Rights/ Authorization for Release	1. I am aware of what information is being released, the purpose and intended use, and who will receive the information. I understand that the information to be released is private, and that any subsequent use and release is controlled under the Minnesota Government Data Practices Act (Minnesota Statutes 1982, Chapter 13). 2. I have been informed of my right to refuse to release this information. 3. I understand that this information is only available to the individual or a parent or legal guardian of the individual for whom the controlled substance was prescribed, and I certify that: <input type="checkbox"/> I am the individual and I am 18 years of age or older. <input type="checkbox"/> I am the parent or legal guardian of the individual. 4. I authorize the MN Prescription Monitoring Program (PMP) to release data about me to the person(s) and/or entity named in Section 3 above.			
	Subject's Signature	Date		
<i>(Must be signed in the presence of the Notary)</i>				
Subscribed and sworn to before me in the County of _____, State of _____,				
this _____ day of _____, 20____.				
			Notary Public Seal	
NOTARY PUBLIC				
My Commission expires: _____				