MNPMP
MINNESOTA PRESCRIPTION MONITORING PROGRAM

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www.pmp.pharmacy.state.mn.us

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 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: ☐ I am the individual and I am 18 years of age or older. ☐ 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** ***(Must be signed in the presence of the Notary)*** Subscribed and sworn to before me in the County of _____, State of _____, this _____ day of _____, 20____. **Notary Public Seal** _____ **NOTARY PUBLIC** My Commission expires: _____