MINNESOTA BOARD OF PHARMACY

Prescription Monitoring Program
2829 University Ave. SE #530
Minneapolis, MN 55414-3251
www.pmp.pharmacy.state.mn.us
Supporting Patient Care Since 2010

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 be submitted along with this form:
  - A **certified copy of the individual's birth certificate** (*showing the requesting parent's name*) or certified copy of court order granting legal guardianship.
- ✓ A PMP Report may be requested by a healthcare agent on behalf on the individual acting in pursuant to a healthcare power of attorney (POA). In order to show of relationship, the following must be submitted along with this form:
  - **Certified healthcare power of attorney document** (showing the requesting individual listed as current healthcare POA).

- ✓ 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.
- ✓ Forms must be submitted within 30 days of notarized signature.
- ✓ **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)

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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 *(required, see rights below)*: **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 data and would otherwise be 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 the information released pursuant to this authorization is only available to the individual, a parent or legal guardian of the individual for whom the controlled substance was prescribed, or a healthcare agent of the individual acting pursuant to a healthcare power of attorney, and I certify that: ☐ I am the individual and I am 18 years of age or older. ☐ I am the parent, legal guardian, or healthcare agent of the individual acting in pursuant to a healthcare power of attorney. 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.
	Signature of Recipient – Parent/Guardian or Healthcare POA w/ documentation **Date** ***(Must be signed in the presence of the Notary, invalid after 30 days)*** Subscribed and sworn to before me in the County of_____, State of _____, this_____day of_____, 20____. **Notary Public Seal** _____ **NOTARY PUBLIC** My Commission expires: _____