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 ReportRequest Form

Any individual who requests information from the Minnesota Prescription Monitoring Program (MN PMP) relating to their personal controlled substance prescription history must complete a request form and submit it by mail, fax, or emailto the MN PMP.

Request forms must be notarized. Notarized forms signed greater than 30 days from receipt will be returned.

Requests must be signed by the recipient or a parent or legal guardian of the individual for whom the controlled substance(s) were prescribed, or a healthcare agent of the individual acting pursuant to a healthcare power of attorney. If the recipient of controlled substances is under 18 or not the requestor of the record one of the following is required to be submitted along with this notarized form:

- ✓ **A certified copy of the individual's birth certificate (*showing the requesting parent's name*),** *or*
- ✓ **Certified copy of court order granting guardianship,** *or*
- ✓ **Certified healthcare power of attorney (*showing the requesting individual listed as current healthcare POA)***

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 within 10 business days of receipt)

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MN Statute 152.126, subd. 5 (d) which states in part, *"Data shall be retained by the board in the database for a 12-month period, and shall be removed from the database no later than 12 months from the last day of the month during which the data was received."*

I request a copy of the report from the MN Prescription Monitoring Program (MN PMP) relating to prescriptions *dispensed to*:

Recipient Name:______________________________________ Date of Birth: ____________________
(First and Last Name) *(Month/Day/Year)*

Requester Information
(Please print legibly or type)

Name ____
First **Middle** **Last**

______________________________________ ______________________________________
Street Address City, State, Zip

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).

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 acting pursuant to a healthcare power of attorney of the individual.

____ ____________________
Signature of Recipient – Parent/Guardian or Healthcare POA w/documentation **Date**

(To 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

My Commission expires: __________________________

NOTE: ***Forms that have not been signed in the presence of a notary public will be returned.***