MINNESOTA BOARD OF PHARMACY

Prescription Monitoring Program

Individual Request for Controlled Substance Prescription History Report

I request the release of my Controlled Substance History as reported to the Minnesota Prescription Monitoring Program - 335 Randolph Avenue, Suite 230, Saint Paul, MN 55102

CLEAR FORM

Subject of Data:	Last Name	First Name	Middle Initial
	Date of Birth ☐☐/☐☐/☐☐☐☐	Phone 1-☐☐☐-☐☐☐-☐☐☐☐	

Choose one:

☐ I am the individual SUBJECT OF THE DATA, and I am 18 years of age or older.

Mail results to:	Address		
	City	State	Zip

☐ **I am the parent, legal guardian, or healthcare agent** acting pursuant to a healthcare power of attorney for the SUBJECT OF THE DATA, and I have attached legal documentation supporting such.

Complete fields below and attach one of the following:

- A copy of the subject's certified birth certificate (showing the requesting parent's name), or
- A copy of a certified court order granting guardianship to the requester, or
- A copy of a certified healthcare power of attorney naming the requesting individual as the current healthcare power of attorney.)

If applicable **Mail results to Parent, legal guardian, or HC POA:**	Parent/guardian or HC POA Last Name	First Name	Middle Initial
	Address	Phone ☐☐☐-☐☐☐-☐☐☐☐	
	City	State	Zip

- Results sent by certified mail only. Must be mailed to a physical address. Unable to send to a P.O. Box.
- If you would like your results sent to a 3rd party, see Individual Authorization to Release Controlled Substance Prescription History to a 3rd Party form.
- MN Statute 152.126, subd. 5(d) 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…*

Explanation of Rights/ Signature

Description of Rights	✓ 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 anysubsequent use and release is controlled under the Minnesota Government Data Practices Act (Minnesota Statutes 1982, Chapter 13). ✓ I understand that this information release 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.
Signature of Subject of Data or authorized legal representative/ Notary **Form must be signed in the presence of the Notary, invalid after 30 days.**	**Signature of Subject** (or parent/guardian or HC POA w/documentation) _____ Date ☐☐ ☐☐ ☐☐☐☐ Subscribed and sworn to before me in the County of _____, State of_____, This _____ day of _____, 20_____. SEAL NOTARY PUBLIC My commission expires: _____

Incomplete, or illegible forms will be returned.

Please submit completed forms via mail, fax, or email to:

Minnesota Board of Pharmacy – Prescription Monitoring Program
333 Randolph Avenue, Suite 230, St Paul, MN 55102

fax. 651.215.0948
email. minnesota.pmp@state.mn.us

Results will be returned within 10 business days. If you have an urgent request, call the program office at **651.201.2836.**