MINNESOTA BOARD OF PHARMACY

Prescription Monitoring Program

CLEAR FORM

Individual Authorization to Release Controlled Substance Prescription History Report to a 3rd Party

I *(subject of data)* authorize the release of my Controlled Substance History as reported to the Minnesota Board of Pharmacy - Prescription Monitoring Program at 335 Randolph Avenue, Suite 230, Saint Paul, MN 55102

Subject of Data	Last Name	First Name	Middle Initial
	Date of Birth	Phone	
	Address		
	City	State	Zip Code

I authorize the release of my Controlled Substance History as reported to the MN PMP be released to *(recipient of data)*.

Recipient of Data	Last Name **required**	First Name **required**	
	Phone	Email	
	Agency optional		
	Address		
	City	State	Zip Code

- Release only allowed to an INDIVIDUAL, not a business/agency/group.
- First and last name is required. Agency is optional.
- If email is provided, results will be returned via secure email. If no email provided results will be returned via certified US mail.

Explanation of Rights/ Signature

The subject of data must be explained their rights regarding release of data as listed in Section 1 below. The individual that explains these rights must sign and date in Section 2, prior to the signature of subject of data. This can be the data recipient, a family member, the notary, or any other individual. Incomplete forms will be returned!

Section 1 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 have been informed of my right to refuse to release this information. ✓ 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 and I have attached legal documentation supporting such. *Request must include a copy of certified birth certificate showing requesting parent's name or copy of certified healthcare power of attorney document showing the requesting individual as HC POA.* ✓ I authorize the MN PMP to release data about me to the person named as Recipient of Data
Section 2 Signature of individual explaining Subject their rights.	I have informed Subject of their rights as listed above. Date _____ _____
Section 3 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 Date _____ _____ Subscribed and sworn to before me in the County of _____, State of _____, This _____ day of _____, 20_____. SEAL _____ NOTARY PUBLIC My commission expires: _____

Please submit completed forms via mail fax or email to:

Minnesota Board of Pharmacy - Prescription Monitoring Program
335 Randolph Avenue, Suite 230, Saint Paul, MN 55102

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

Requests will processed within 10 business days of receipt.
If you have questions, please call the program office at 651.201.2836.