
MN PMP Account Audit Response Form

The following form is required to be completed and returned via email within 30 days of receipt of a *Notice of Random Audit*.

MN PMP Account Holder

First Name:

Last Name:

Email Address/User Name associated with MN PMP Account:

License Number associated with MN PMP account (if applicable):

Affirmation

I affirm that all requests for patient data performed between 02/01/2020 and 02/29/2020, using the MN PMP account belonging to me, the above noted account holder, were conducted in accordance with the permissible use clause stated in [Minnesota Statutes Section 152.126, Subd\(6\)](#).

Signature (e-signature):

Date:

If you have questions regarding suspected impermissible use, please immediately contact the MN PMP staff by email at: minnesota.pmp@state.mn.us

(Required)