Office Use Only

_____/_____/_____

Date Received

_____

Request Number

OREGON PRESCRIPTION DRUG MONITORING PROGRAM
PATIENT RECORD REQUEST

Please print or type, use full name (first, middle, last, suffix (Jr., Sr., II, etc.)
Complete the appropriate blanks below. Read and follow all instructions. Sign and date on page 2.

1. **If you are requesting a copy of your own prescription report, please fill out the information below and attach a photocopy of your current driver's license or other valid government issued photo identification:**

_____ _____

Full Name of Patient | Date of Birth (DD/MM/YYYY)

_____

Mailing Address of Patient (City, State, Zip) and contact phone number.

2. **If you are the patient but want the report sent to someone other than you, please fill out the information below and attach an Authorization for Use and Disclosure of Information and a photocopy of your current driver's license or other valid government issued photo identification** [Go to www.orpdmp.com/patient-rights/ for a copy of the authorization form]**:**

_____ _____

Full Name of Patient | Date of Birth (DD/MM/YYYY)

_____

Full Name of Person/Entity the report should be sent to

_____

Mailing Address of Recipient (City, State, Zip) and contact phone number.

3. **If you are an Authorized Representative of the patient and you are requesting a copy of the patient's prescription report, please fill out the information below and attach documentation that demonstrates you have the legal authority to request and receive the report, and attach a photocopy of your current driver's license or other valid government issued photo identification:**

_____ _____

Full Name of Patient | Date of Birth (DD/MM/YYYY)

_____

Full Name of Authorized Representative

_____

Mailing Address of Authorized Representative and contact phone number.

4. If you are a parent of a minor patient, please fill out the information below and attach a copy of your child's birth certificate and a photocopy of your current driver's license or other valid government issued photo identification:

_____ _____

Full Name of Patient Date of Birth (DD/MM/YYYY)

_____

Full Name of Authorized Representative

_____

Mailing Address of Authorized Representative and contact phone number.

5. Mail this application and supporting document to:

Oregon Prescription Drug Monitoring Program - IPE
OREGON HEALTH AUTHORITY
PO Box 14450
Portland, OR 97293-0450

Applicant Attestation:

I declare under penalty of false swearing with a maximum potential jail term of one (1) year and maximum potential fine of $6,250 that this application (including any accompanying document) has been examined by me and, to the best of my knowledge and belief, is true, correct, and complete.

Signature: _____ **Date**: _____

Note: The program did not begin collecting information until June 1, 2011 and personal information is destroyed after three (3) years, so prescription history is limited to that timeframe.