



# COMMONWEALTH OF VIRGINIA

## Virginia Department of Health Professions

### *Prescription Monitoring Program*

#### *Perimeter Center*

9960 Mayland Drive, Suite 300  
 Richmond, Virginia 23233  
 Phone: (804) 367-4514  
 Fax: (804) 527-4470  
 Email: [pmp@dhp.virginia.gov](mailto:pmp@dhp.virginia.gov)  
 Web site: [www.dhp.virginia.gov](http://www.dhp.virginia.gov)

## RECIPIENT REQUEST FOR DISCRETIONARY DISCLOSURE OF INFORMATION FROM THE PRESCRIPTION MONITORING PROGRAM

Please provide the information requested below. (Print or Type) Use full name not initials

Full Name:	Street Address:		
Mailing Address (if different from street address):	City:	State:	
Zip Code:	Area Code and Telephone Number:		
Specific time period to be covered in report (data is limited to two years only):	Date of Birth:	Signature of person making request:	

Request must be accompanied by a copy of a valid photo identification issued by a government agency of any jurisdiction in the United States verifying that the recipient is over the age of 18.

Request form must include a notarized signature.

Subscribed and sworn to me, a notary public in and for the Commonwealth of Virginia at large, on this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_. My commission expires on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

Mailing Address of Entity or Individual if Report is to be Mailed to Address Other than Recipient's address :

Name of Entity:	Attention:		
Address:			
City:	State:	Zip Code:	

#### For Department Use Only

Date Received:	Date of action:	<input type="checkbox"/> Approved	Director or Designee Signature:
		<input type="checkbox"/> Rejected	