COMMONWEALTH OF VIRGINIA

Virginia Department of Health Professions

Prescription Monitoring Program

Perimeter Center

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233
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Email: pmp@dhp.virginia.gov
Website: www.dhp.virginia.gov

REGULATORY AUTHORITY 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		**Case Identifier Number**
Agency Name (If applicable)		**Street Address**
City		**State**
Zip Code	**Area Code and Telephone Number**	**Area Code and Fax Number**
Purpose of Request:		
Specific time period to be covered in report:		
☐ **Patient information:** **Name:**	**Address:**	**Date of Birth**
☐ **Prescriber:** **Name:**	**Virginia License or DEA Number:**	**Address:**
☐ **Dispenser:** **Name:**	**Virginia License or DEA Number:**	**Address:**

I hereby attest that the requested information will not be further disclosed and will only be used for the purposes stated in the request and in accordance with the law.

Signature: _____ **Date:** _____

Additional signature for regulatory authority requesting information.

Executive Officer: _____
(Print Name)

Signature: _____ **Date:** _____

For Department Use Only

Date Received	**Director or Designee Signature:**	**Date of action**