



# COMMONWEALTH OF VIRGINIA

## Virginia Department of Health Professions

### Prescription Monitoring Program

#### Perimeter Center

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Website: [www.dhp.virginia.gov](http://www.dhp.virginia.gov)

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

<b>Please provide the information requested below. (Print or Type) Use full name not initials</b>		
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:		
<input type="checkbox"/> Patient information: Name:	Address:	Date of Birth
<input type="checkbox"/> Prescriber: Name:	Virginia License or DEA Number:	Address:
<input type="checkbox"/> 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: _____
<b>For Department Use Only</b>		
Date Received	Director or Designee Signature:	Date of action