MINNESOTA BOARD OF PHARMACY

Prescription Monitoring Program

Recipient Audit History Request Form

Minnesota Statute 152.126, subd. 11 which states in part, *A patient who has been prescribed a controlled substance may… obtain information on access by permissible users to the patient's data record… In order to obtain this information, the patient must complete, notarize, and submit a request form developed by the board.*

I request an audit history report relating to access of controlled substance dispensations records as reported to:
Minnesota Prescription Monitoring Program - 335 Randolph Avenue, Suite 230, Saint Paul, MN 55102

CLEAR FORM

Subject of Data:	Last Name	Middle Name
	First Name	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
	Email Address	Contact Phone 1 - ☐☐☐ - ☐☐☐ - ☐☐☐☐
	Address	City, State, Zip

☐ Check box if you would like to request a MN PMP Controlled Substance History Report as well.
(Prescription data is sent by certified mail only, will delay results.)

- Controlled Substance History Reports ***must*** be mailed via certified us mail. If selected, both results will be mailed via certified mail to the address listed above. If requesting Audit History only, results will be sent via secure email.
- Results ***cannot*** be mailed to a post office box.
- MN Statute 152.126, subd. 5(d) states in part, *…data shall be retained by the board in the database for a 12-month period, and shall be removed from the database no later than 12 months from the last day of the month during which the data was received…* (12 months of data is retained for release.)

Description of Rights/ Signature

Description of Rights	✓ I am aware of what information is being released, the purpose and intended use, and who will receive the information. I understand that the information to be released is private, and that anysubsequent use and release is controlled under the Minnesota Government Data Practices Act (Minnesota Statutes 1982, Chapter 13). ✓ I understand that this information release pursuant to this authorization is only available to the individual, a parent or legal guardian, of the individual for whom the controlled substance was prescribed, or a healthcare agent of the individual acting pursuant to a healthcare power of attorney.
Signature of Subject of Data or authorized legal representative/ Notary **Form must be signed in the presence of the Notary, invalid after 30 days.**	**Signature of Subject** _____ Date ☐☐ ☐☐ ☐☐☐☐ Subscribed and sworn to before me in the County of _____, State of_____, This _____ day of _____, 20_____. SEAL NOTARY PUBLIC My commission expires: _____

Incomplete, or illegible forms will be returned.

Please submit completed forms via mail, fax, or email to:

Minnesota Board of Pharmacy – Prescription Monitoring Program
333 Randolph Avenue, Suite 230, St Paul, MN 55102

fax. 651.215.0948
email. minnesota.pmp@state.mn.us

Results will be returned within 10 business days.
If you have questions, call the program office at 651.201.2836.