

PATIENT REPORTS

The District of Columbia Prescription Drug Monitoring Program (PDMP) will provide a report of stored prescription monitoring information that pertains to a patient, directly to the patient, or to the parent or legal guardian of the patient ([DCMR 10308.2](#)).

Note: If you are a practitioner who wishes to receive a patient's prescription records, click [Login](#).

- **To request your own Prescription Report**, submit a completed, signed and notarized [Request for Prescription Report - Self](#).
 - Enclose a photocopy of your valid government-issued identification with the form.
- **If you are a patient's parent or legal guardian**, submit a completed, signed and notarized [Request for Prescription Report - Representative of Patient](#).
 - Enclose a photocopy of your valid government-issued identification.
 - If the patient is an adult, submit documentation showing that you are the patient's parent or legal guardian.
 - If the patient is a minor, submit documentation that you are the patient's custodial parent or legal guardian.

Obtaining Reports

- The PDMP Prescription Report will be available for pickup at the address listed in the footer.
- Reports can be obtained during normal business hours, every second and fourth Wednesday of the month.
- Reports will be saved as "PDMP Recipient Report" on an encrypted disc.
- The disc code will be provided during pick up.
- Recipients must have a valid government ID to obtain the file.

REQUEST FOR PRESCRIPTION REPORT- REPRESENTATIVE OF PATIENT

INSTRUCTIONS

Use this form to request prescription records for a person for whom you are a representative.

- This form is not for healthcare providers use. If you are a provider who wishes to obtain a patient's prescription records, refer to the DC Prescription Drug Monitoring Program – click on Login under [Healthcare Provider](#).

- This form is not for use of the actual patient. If you are a patient seeking your PDMP records, submit your request using the [Request for Prescription Report - Self](#).

You may request the prescription records of a patient as a representative if you are a:

- Legal guardian or other recognized, authorized representative of an adult patient.
- Parent with custody of or the guardian of a minor patient.

To request patient records:

- Submit completed, signed and notarized request form.
- Enclose a copy of a valid photo identification issued by a government agency in any jurisdiction in the U.S.
- If the patient is an adult, submit documentation showing that you are his/her parent or legal guardian
- If the patient is a minor, submit documentation that you are the patient's custodial parent or legal guardian.
- Send the form and ID to the Prescription Drug Monitoring Program. Use the address in the footer.

INFORMATION ABOUT THE PATIENT

1. Patient Full Name: _____
First Middle Last/Family Suffix

2. Other Names Used: _____
(Include maiden, other married, alternative spellings.)

3. Patient Date of Birth (mm/dd/yyyy): _____ Gender: Male Female

4. Patient Mailing Address: _____

City State/Province Zip/Postal Code Country

5. Phone: _(_____)_ _____ - _____ Email: _____

6. Dates of prescriptions to be included in the report
(no earlier than 12/15/2015): From: _____ To: _____
(mm/dd/yyyy) (mm/dd/yyyy)

(CONTINUED)

INFORMATION ABOUT REPRESENTATION

7. Check the item that describes your representation of the patient named above:

- Legal Guardian – I am the legal guardian of the adult patient named above.
- Parent/Guardian – I am the custodial parent or legal guardian of the minor patient named above.
- Other Representative – Explain: _____

8. **Your Mailing** Address: _____

_____ City _____ State/Province _____ Zip/Postal Code _____ Country

9. Phone: () _____ - _____ Email: _____

10. Do you understand that a person who is not authorized to have prescription monitoring information and who obtains such records fraudulently may be fined or imprisoned, or both Yes: No:

AFFIDAVIT

The undersigned, being sworn, deposes and says that he or she is the person named above; that all statements and answers herein are truthful; that he or she has not suppressed any information that might affect this request

Signature of Requester: _____ Date: _____

Sworn to before me and subscribed in my presence this _____ day of _____ 2_____.

Signature of Notary: _____ SEAL: _____ Expiration Date: _____

REQUESTS THAT ARE UNSIGNED, NOT NOTARIZED, OR INCOMPLETE WILL BE REJECTED.