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.

899 North Capitol Street NE | 2nd Fl, Washington, DC 20002 | E doh.pdmp@dc.gov | https://dchealth.dc.gov/pdmp

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INSTRUCTIONS

Use this form to request your own prescription records.

- 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 parents, guardians or other representatives of patients. If you are a parent, legal guardian or representative of a patient, submit Request for ***Request for Prescription Report - Representative of Patient***.

☐ 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.
☐ Send the form and ID to the Office of Controlled Substances at the address in footer.

REQUEST FOR PRESCRIPTION REPORT - SELF

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

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

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

4. 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)

7. 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.

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