



PATIENT PDMP DATA REQUEST FORM

Instructions:

- Provide the information requested below. Incomplete, unsigned, or mailed-in forms that are not notarized will not be processed.

- Do one of the following:
 - Appear in person at the address below with two forms of valid proof of identity, one of which is valid government-issued photographic identification, and, if you are requesting PDMP data on behalf of a patient, sufficient proof of the authorization or delegation from the patient.

 - Have this form notarized and mail it, along with copies of two forms of valid proof of identity, one of which is valid government-issued photographic identification, to the address listed below. The report will only be mailed to the address on the forms of identification.

**Wisconsin Department of Safety and Professional Services
Prescription Drug Monitoring Program (PDMP)
4822 Madison Yards Way
Madison, WI 53705-9100**

Name of Patient			
Name of Person Requesting PDMP Data (if different than the patient)		Type of Authorization from Patient	
Patient Street Address	City	State	ZIP Code
Phone Number (with Area Code)	E-Mail Address		
Request Date Range <div style="text-align: center;"> __ / __ / ____ to __ / __ / ____ </div>			
<p>By signing this form, I certify that:</p> <ol style="list-style-type: none"> 1) I am or have been authorized to obtain PDMP data by the patient identified above. 2) I understand that the Department of Safety and Professional Services and Controlled Substances Board make no claims, promises, or guarantees about the accuracy, completeness, or adequacy of the contents of this report and expressly disclaim liability for errors and omissions in the contents of this report. The PDMP database is an accumulation of information submitted to it by Wisconsin-licensed pharmacies and dispensing healthcare practitioners. I will verify all information before making any decisions or taking any action. For more information about any information in this report or to verify a prescription, I will contact the pharmacy or dispensing practitioner. 			
Signature			Date
Attestation of the Signature **REQUIRED IF THIS FORM IS MAILED**			
STATE OF _____			
COUNTY OF _____			
Signed before me on _____ by _____			
(date)		(name of person)	
Notary Public Signature: _____			
Title and Rank: _____			
Printed Name: _____			
My Commission Expires: _____			
(Seal, if any)			

FOR OFFICE USE ONLY				
Date Received	ID 1 Type	ID 2 Type	Authorization	Date of Action
Approved Denied	Notes			