TEXAS STATE BOARD OF PHARMACY

1801 Congress Avenue, Suite 13.100 ✯ Austin, Texas 78701 ✯ 512-305-8000

PRESCRIPTION MONITORING PROGRAM
PATIENT ACCESS REQUEST FORM

PATIENT'S INFORMATION:	
First Name:	Middle Name:
Last Name:	Social Security Number:
Date of Birth:	Driver's License or State Identification Number:
Phone Number:	Email Address:

PLEASE CHECK THE BOX (OR BOXES) FOR THE INFORMATION BEING REQUESTED:

- ☐ Patient's prescription history record
- ☐ List of persons who have accessed patient record

TO BE COMPLETED BY PATIENT:

I have included the following required items with this request:

- ☐ *Copy of my Driver's License or State Identification Card
- ☐ *Copy of my Social Security Card
- ☐ $50 fee (Cashier's Check or Money Order payable to the Texas State Board of Pharmacy)

*Each document shall be individually copied. A notary public shall certify each individual copy by including and completing the following certification statement on the page containing the copy (the attached pages may be used for copies and notary certification):

"County of _____, State of _____. I, _____, a Notary Public, certify this __ day of _____, 20_, the foregoing document is a true, correct, complete, and unaltered copy of (describe requested item), made by (name the individual who made the copy).

Notary Public Seal _____ Signature of Notary Public My commission expires: _____"

☐ I understand that under section 481.127 of the Texas Controlled Substances Act, knowingly obtaining, giving, or permitting unauthorized access to PMP information is a state jail felony.

Signature: _____ Date: _____

Sworn to and subscribed before me in the County of _____, State of _____, on the _____ day of _____, 20___.

_____
SIGNATURE OF NOTARY PUBLIC

Notary Public Seal My commission expires:

*Please contact the Board if you do not have a mailbox at the address listed on your driver's license or state identification card.

PATIENT ACCESS REQUEST FORM (CONTINUED)-
DRIVER'S LICENSE OR STATE IDENTIFICATION CARD CERTIFICATION PAGE

(Copy of driver's license or state identification card must be copied directly to this page; a copy cut from another page and affixed hereto is not acceptable.)

County of _____, State of _____. I, _____, a Notary Public, certify this ___ day of _____, 20___, the foregoing document is a true, correct, complete, and unaltered copy of _____, made by _____.
(describe item) (name of individual who made copy)

_____
SIGNATURE OF NOTARY PUBLIC

Notary Public Seal

My commission expires:

PATIENT ACCESS REQUEST FORM (CONTINUED)-
SOCIAL SECURITY CARD CERTIFICATION PAGE

(Copy of social security card must be copied directly to this page; a copy cut from another page and affixed hereto is not acceptable.)

County of _____, State of _____. I, _____, a Notary Public, certify this ___ day of _____, 20___, the foregoing document is a true, correct, complete, and unaltered copy of _____, made by _____.
(describe item) (name of individual who made copy)

_____
SIGNATURE OF NOTARY PUBLIC

Notary Public Seal

My commission expires: