Patient Request for Prescription Monitoring Program (PMP) Information

Iowa Board of Pharmacy
6200 Park Ave Ste 100
Des Moines, IA 50321
515-281-5944
https://dial.iowa.gov/about/boards/pharmacy

Requests may be personally delivered to a PMP administrator at the offices of the Board located at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. Patients will be required to present current government-issued photo identification at the time of the delivery of the request. A copy of the patient's identification shall be maintained in the records of the PMP.

A person who is unable to personally deliver the request to the Board offices may submit a request via mail or commercial delivery service. The request shall be a sworn, signed statement witnessed by a currently registered notary public with a copy of the patient's government-issued photo identification. The notary public shall certify the copy of the patient's government-issued photo identification by including and completing the certification statement on the attached page.

The following agents may submit a request on behalf of a patient: an individual with a medical power of attorney for the patient, a patient's attorney, or an executor of the patient's estate. In addition to the patient's information, the patient's agent shall be identified by name, current address, and telephone number. In lieu of the patient's signature and identification, the patient's agent shall sign the request and the government-issued photo identification shall identify the patient's agent. The patient's agent shall include a copy of the legal document that establishes the agency relationship with the patient.

Please print clearly

PATIENT INFORMATION:						
Full Legal Name:	**(Last)**		**(First)**		**(Middle)**	
Date of Birth (MM/DD/YYYY):		**Gender:**	Male ☐	Female ☐	Other:	
Previous/Other Name(s) Used:						
Phone #:						

Current Street Address:					
Address Line 2 (*Optional*):					
City:		**State:**		**Zip Code:**	
County:		**Fax #:**			

Other Address:					
Other Address Line 2 (*Optional*):					
City:		**State:**		**Zip Code:**	

Other Address:					
Other Address Line 2 (*Optional*):					
City:		**State:**		**Zip Code:**	

DATE RANGE OF PRESCRIPTIONS REQUESTED			
Last 12 Months: ☐	OR	Begin Date:	End Date:

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Patients who are submitting this request via mail or commercial delivery service must include this page. A copy of photo identification must be copied directly to this page; a copy cut from another page and affixed hereto is not acceptable.

The request shall be a sworn, signed statement witnessed by a currently registered notary public with a copy of the patient's government-issued photo identification. The notary public shall certify the copy of the patient's government-issued photo identification by completing the certification statement on this page.

Copy ID into the box below:

PATIENT ATTESTATION AND SIGNATURE:

I, _____ (*Patient or patient's agent printed name*), hereby certify that the information provided is true and correct, that all names and addresses used by me during the date range indicated have been provided, and that I am the individual whose information I am requesting.

Signature of Patient or Patient's Agent:	
Date:	

NOTARY CERTIFICATION STATEMENT AND SIGNATURE:

State of _____, County of _____

I, _____ (*Notary's printed name*), a Notary Public, certify this _____, day of _____ (*Month*), 20_____ (*Year*), the foregoing document is a true, correct, complete, and unaltered copy of _____ (*Describe photo ID*), made by _____ (*Name of the individual who made the copy of the ID*). I further certify that I did witness _____ (*Patient's printed name*) sign above certifying the contents of this document in their entirety.

Signature of Notary Public:		
Commission Number:		
Commission Expiration Date:		Notary Stamp