Florida's Prescription Drug Monitoring Program
4052 Bald Cypress Way, Bin C-16
Tallahassee, FL 32399
Phone: (850) 245-4797
Fax: (850) 617-6430
e-forcse@flhealth.gov

Patient Information Request

64K-1.003(6), Florida Administrative Code, requires that a patient or their representative appear in person at the Program office and produce proof of representation (if not the patient) as well as a government issued photographic proof of identity to receive the patient information report. Please contact the Program office at (850) 245-4797 or via email at eforcse@doh.state.fl.us prior to your visit, to make an appointment.

FORM INSTRUCTIONS: This is an adobe fillable form. Once complete, click on the "Submit Form" button in the purple box at the top of the form to submit a preliminary copy of the form to E-FORCSE staff. Type in your email address and full name and click send. Print the completed form and have notarized. Bring notarized form to scheduled appointment to collect the Patient Information Request.

Patient Information				
Name	Date of Birth (MM/DD/YYYY)	Driver's License Number		
Address	City	State	Zipcode	
E-mail address	Telephone Number	Reporting Period to		

_____ _____
Patient Signature Date

State of Florida
County of _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, _____ (year), by _____ (name of person making statement).

_____
(Signature of Notary Public - State of Florida)

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known OR Produced Identification

Type of Identification Produced _____

IF THIS REQUEST IS BEING MADE BY A LEGAL GUARDIAN OR DESIGNATED HEALTH CARE SURROGATE ON BEHALF OF THE ABOVE REFERENCED PATIENT, PLEASE COMPLETE THE SECTION BELOW.

[CONTINUED ON NEXT PAGE]

Legal Guardian/Designated Health Care Surrogate Information			
Name	Date of Birth (MM/DD/YYYY)	Driver's License Number	
Address	City	State	Zipcode
E-mail address	Telephone Number		

Relationship to patient
☐ Parent
☐ Legal Guardian (Please attach a copy of court order granting guardianship)
☐ Designated Health Care Surrogate (Please attach a copy of the court order granting surrogacy)

_____ _____
_ Date
Legal Guardian/Designated Health Care Surrogate Signature

State of Florida
County of _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, _____ (year), by _____ (name of person making statement).

_____
(Signature of Notary Public - State of Florida)

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known OR Produced Identification

Type of Identification Produced _____

For Department Use Only

Date Received	☐ Approved ☐ Denied	PDMP Staff Signature	Date of Action