COLORADO
Department of
Regulatory Agencies
Division of Professions and Occupations

Healthcare Branch
Colorado Prescription Drug
Monitoring Program (PDMP)

Colorado State Board of Pharmacy
Prescription Drug Monitoring Program

**Confidential Patient Information Request for 3rd Party Representatives**

Representative Information:

Name: _____ Driver's License Number: _____

Address: _____ City/State/ZIP: _____

Phone number: _____

Please Provide Copies of the Following:
a) Driver's License from state of residence.
b) Copy of legal documentation appointing representation

Patient Information:

Name: _____ Date of Birth: _____

Address: _____ City/State/ZIP: _____

Date range for the patient report _____

I acknowledge and verify the information I am accessing is for a patient I have legal authority to do so. I understand that if I release, obtain, or attempt to obtain information from the program in violation of CRS 12-42.5-404, I may be fined for each violation.

Representative Signature: _____ Date: _____

Mail to 1560 Broadway, Ste. 1350, Denver, CO 80202
Fax to 303-869-0133/e-mail to: pdmpinqr@state.co.us