Healthcare Branch
Colorado Prescription Drug
Monitoring Program (PDMP)

Colorado State Board of Pharmacy
Prescription Drug Monitoring Program

Confidential Patient Information Form

Personal Information:

Name: _________________________________ Date of Birth: _________________________

Address: _______________________________ City/State/ZIP: __________________________

Driver's License Number: ________________ Phone: ________________________________
(***In order to process each request you must submit a front and back copy of your Driver's License***)

Email of Patient: ______________________________

Date range for the patient report: ____________________

The report will be sent encrypted to the email address listed above through our secure system

I acknowledge and verify with my signature that I am the person listed above under "Personal Information" and that the information I am requesting is for my personal reasons and is to be sent to my personal email address". 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.

Signature: ______________________________ Date: _________________

Mail to:
Colorado Prescription Drug Monitoring Program
1560 Broadway, Ste. 1300, Denver, CO 80202
Fax to 303-869-0133
E-Mail to pdmpinqr@state.co.us