CONNECTICUT DEPARTMENT OF CONSUMER PROTECTION
PRESCRIPTION MONITORING PROGRAM

PRESCRIBER REQUEST FORM

Instructions: All sections must be completed before any information can be released. The Director of the Drug Control Division will have final approval for any prescriber requesting patient dispensed (Schedule II-V controlled substances) prescription information.

PATIENT'S FULL NAME

DATE OF BIRTH

ADDRESS

CITY STATE ZIP

PURPOSE OF REQUEST

SPECIFIC TIME PERIOD TO BE COVERED IN REPORT

For Department Use Only

Date Received

☐ Approved ☐ Disapproved

Directorr or Designee Signature

Date of Action

PRESCRIBER INFORMATION

PRESCRIBER NAME

DEA REGISTRATION NUMBER

ADDRESS

CITY STATE ZIP

TELEPHONE FAX

I hereby attest that I have received written consent to request this information and that the requested information will not be further disclosed and will only be used for the purposes stated in the request and in accordance with the law.

SIGNATURE DATE

Mail or fax to: State of Connecticut Department of Consumer Protection Prescription Monitoring Program, 165 Capitol Avenue, Room 145, Hartford, CT 06106, Telephone: (860) 713-6073, Fax: (860) 622-2608