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

FORM INSTRUCTIONS: This is an adobe fillable form. Print the completed form and have notarized. Send the completed, notarized form to e-forcse@flhealth.gov.

Check one: ☐ I am the Patient ☐ I am the Legal Guardian/Designated Health Care Surrogate			
Name	Date of Birth (MM/DD/YYYY)	Driver License Number	
Address	City	State	ZIP code
Email 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 _____

For Department Use Only

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