ARIZONA STATE BOARD OF PHARMACY
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REQUEST FOR AN INDIVIDUAL'S OWN CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM DATABASE INFORMATION

Please print legibly or type, and use full name [first, middle, last, suffix (Jr., Sr., II, III, etc.) - do not use initials]
Include a clear photocopy of your driver license or ID with the request.

Full Name:		
DOB:	**Email Address:**	
Street Address:		
City / County:	**State:**	**Zip Code:**
Phone Number:	**Fax Number:**	
Specific time period to be covered in report **Start Date:**	**End Date:**	

Note: Information cannot be delivered to third parties.

Delivery Method ☐ **Mail** ☐ **Fax** ☐ **Pick up (at Board Office)** ☐ **Email**

Signature: Date:

Subscribed and sworn to before me in the County of__________________________, State of ______________________________

this _____ day of_______________________________, 20____.

Notary Public Signature

Pursuant to A.R.S. § 36-2610, a person who is granted access to information from the program and who knowingly discloses the information in a manner inconsistent with a legitimate professional of regulatory purpose, a legitimate law enforcement purpose, the terms of a court order or as otherwise expressly authorized by A.R.S. Title 36, Chapter 28 is guilty of a class 6 felony.

Mail the following items to the ASBP Controlled Substances Prescription Monitoring Program:
* Notarized Request for Information Form
* Photocopy of Current Driver License or ID