THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

PDMP

FOR DIVISION USE ONLY
DO NOT KOFAX

Prescription Drug Monitoring Program (PDMP)
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Website: *PDMP.Alaska.Gov*

Patient Record Request

Instructions

- Part I – Use the attached credit card payment form or make certified check or money order payable to "State of Alaska."
- Part II – Provide the personal details of the patient for whom prescription history is being requested.
- Part III – If you are the authorized representative or parent/guardian of a minor patient, incapacitated adult, or deceased individual you must also fill out this section.
- Part IV – Sign and notarize this form.
- Proof of Identity is required.
  - If you are the patient, please include a copy of your current driver's license or other valid government issued photo identification (state ID, real ID, military or other federal identification, or passport).
  - If you are the authorized agent, attach a valid power of attorney concerning the patient or verification you are the parent/guardian, legal administrator, or agent of a minor, incapacitated adult, or deceased individual.
- **Records requests are limited to the previous two years from the date the request is received.**
- Incomplete requests will not be processed. Do NOT email this form.

PART I Payment of Fees

Required Fee:	☐ Patient Record Request	**$10.00**
Delivery Method: (Select One)	☐ Mail ☐ In person, please email *akpdmp@alaska.gov* to schedule a pick-up day and time.	

PART II Personal Information

Full Legal Name:		**Date of Birth:**	

Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).

☐ Not Applicable
☐ Other Names Used: _____

Physical Address:	Street	City	State	Zip
Previous Physical Address:	Street	City	State	Zip
Mailing Address:	P.O. Box or Street	City	State	Zip

PART III Authorized Representative or Parent/Guardian of Patient

Patient Name:			
Relationship: (Select One)	☐ Authorized Representative ☐ Parent/Guardian ☐ Not Applicable		
Requestor Name:	First Middle Last		
Mailing Address:	P.O. Box or Street City State Zip		
Phone Number:		**Email Address:**	

PART IV Notarized Signature

I hereby certify that I am the person herein named and subscribing to this application and that I have read the complete application, and I know the full content thereof. I declare that all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice in the state of Alaska.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Notary Stamp	**Requestor Printed Name:**			
	Requestor Signature:			
	Relationship to Patient:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

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Phone: (907) 465-2550

Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Profession Type (e.g., Acupuncture):

License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(fine, exam, etc.)*: _____ _____

1. _____ _____
2. _____ _____

TOTAL: _____

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

Signature of Credit Card Holder: X _____

08-4438 Rev 12/06/2022 Credit Card Payment Form (all major cards accepted)

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!

1. Credit Card Number: -
2. Expiration Date: -
3. Security Code: -

All 3 fields **MUST** be completed!

This section will be destroyed after the payment is processed.