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 99811-0806
Phone: (907) 465-2550
Website: *PDMP.Alaska.Gov*

Patient Request for Record Correction of Information In Prescription Drug Monitoring Program

A patient may request that the Prescription Drug Monitoring Program (PDMP) correct any information about the patient that is considered incorrect. The request must be made in writing and must state what specific information the patient considers incorrect. This would include the date the report was run, the date the prescription was written and filled, and any other information to positively identify the record in question.

Instructions

- Please provide the information requested below. (Print or Type) Use full legal name - not initials.
- Proof of identity, if the requestor is the patient (e.g.: state ID, driver's license, real ID, military or other federal identification, passport).
- If this request is from an authorized agent, attach your proof of patient authorization or verification of your authorized agent status.
- PDMP staff will review the request and, if justified, will make changes to the database information.
- Fill out the personal details (Part 1), then identify the type(s) of discrepancy and provide an explanation for the basis of the correction request (Part 2).
- Mail this request and supporting documentation to the address in the letterhead above.

PART I Personal Details

Full Name of Patient:		Date of Birth:	
Physical Address of Patient:			
Previous Physical Address of Patient:			
Mailing Address of Patient:			
Written Date of Prescription:		Phone Number:	
Fill Date of Prescription:			

PART II Correction Details

Indicate the type(s) of correction below. Provide any appropriate details and documentation to support the correction requested.

☐ 1. Personal details (check all that apply)

- ☐ a. Name
- ☐ b. DOB
- ☐ c. Address
- ☐ d. Other (explain): ___________________________________

Describe the change(s) needing to be made and attach any documentation necessary to support the correction:

☐ 2. Prescription information (check all that apply)

- ☐ a. Drug name
- ☐ b. Drug type
- ☐ c. Quantity
- ☐ d. Other (explain): ___________________________________

Describe the change(s) needing to be made and attach any documentation necessary to support the correction:

☐ 3. Provider/Pharmacy information

- ☐ a. Name of provider
- ☐ b. Name of pharmacy
- ☐ c. Other (explain): ___________________________________

Describe the change(s) needing to be made and attach any documentation necessary to support the correction:

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Notary Signature Page

Patient Name:	

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