



THE STATE of ALASKA

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

PHA

FOR DIVISION USE ONLY

Board of Pharmacy
PO Box 110806, Juneau, AK 99811-0806
Phone: (907) 269-8404
Website: ProfessionalLicense.Alaska.Gov/BoardOfPharmacy

Patient Records Request

Instructions

- Please provide the information requested below. (Print or Type) Use full legal name – not initials.
If the record is going to an authorized representative or you are the parent or guardian of a minor patient, then fill out Section 2 also.
Attach a photocopy of current driver’s license or other valid government issued photo identification.
Attach all supporting documents:
Attach proof of patient authorization or verification of your authorized representative status, or
Attach a copy of minor patient’s birth certificate
Include fee: \$10 / Certified check or money order must be made payable to ‘State of Alaska’.
Incomplete requests will not be processed.

1. I am requesting a copy of my prescription information. (Complete all blanks below)

Patient Name (Full):

Maiden/Alias: Date of Birth: month/day/year

Physical Address: Street City State Zip Code

Mailing Address: Street or PO Box City State Zip Code

Specific Timeframe to be Covered: From month/day/year To: month/day/year

Note: Prescription records are destroyed after two (2) years, so records are limited to that timeframe.

2. I am the authorized representative, or parent/guardian of the patient listed above. (Complete all blanks below)

Relationship (Select One): Authorized Representative Parent/Guardian

Requestor Name:

Mailing Address: Street or PO Box City State Zip Code

Mail this application and supporting document to:

Alaska State Board of Pharmacy
Alaska Prescription Drug Monitoring Program
550 West 7th Avenue, Suite 1500
Anchorage, AK 99501-3567

AFFIDAVIT

State of _____ City/Borough of _____

I, _____ hereby state under penalty of unsworn falsification: That I am the patient or authorized representative or parent/guardian for the patient named above and to the best of my knowledge and belief, this statement is true and correct.

Signature: _____ Date: _____

AS 11.56.210(a)(2) of the Alaska Statutes makes it a class A misdemeanor of offense for a person to intentionally issue a false written or recorded statement, which is punishable by imprisonment for not more than one (1) year, a \$5,000 fine, or both.

FOR DEPARTMENT USE ONLY	
Date Received:	<input type="checkbox"/> Approved
Date Processed:	<input type="checkbox"/> Disapproved
By: _____	