GEORGIA'S PRESCRIPTION DRUG MONITORING PROGRAM
40 PRYOR STREET S.W. SUITE 2000
ATLANTA, GEORGIA 30303
(800) 656-6568
http://www.gdna.georgia.gov

Patient Information Request

16-30-60 Privacy and confidentiality; use of data; security program
(c) The agency shall be authorized to provide requested prescription information collected pursuant to this part only as follows:
(2) Upon the request of a patient, prescriber, or dispenser about whom the prescription information requested concerns or upon the request on his or her behalf of his or her attorney
Please complete this form and mail to the address above with two forms of Government Issued Identification of the patient. Please contact the Program office at (800) 656-6568 or via email at gapdmp@gdna.ga.gov, if you have any questions.

Please print or type legibly.

Patient Information			
Applicant Name	**Address**		
City	**State**	**Zip**	**Phone Number**
Email Address	**Drivers License Number**		**Date of Birth (MM/DD/YYYY)**
Reporting Period	**From**		**To**

_____ _____
Patient Signature Date

State of Georgia
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 Georgia)

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known OR Produced Identification

Type of Identification Produced _____

IF THIS REQUEST IS BEING MADE BY AN ATTORNEY ON BEHALF OF THE ABOVE REFERENCED PATIENT, PLEASE COMPLETE THE SECTION BELOW.

ATTORNEY			
Name	**Address**		
City	**State**	**Zip**	**Phone Number**
Email Address	**Drivers License Number**		**Date of Birth (MM/DD/YYYY)**

_____ _____

Attorney Signature Date

State of Georgia
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 Georgia)

_____

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known OR Produced Identification

Type of Identification Produced _____

Unless otherwise noted here your patient information will be emailed to the email address that is provided above.

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