Georgia Prescription Drug Monitoring Program
Georgia Drugs & Narcotics Agency
254 Washington Street, SW - Suite G2000
Atlanta, GA 30334
Telephone: 404.656.5102 Toll Free: 800.656.6568 Fax: 404.651.8210

Patient GAPDMP Data Request Form

For a patient to complete and submit when requesting a copy of their personal data from the Georgia Prescription Drug Monitoring Program

(completed forms and attachments should be mailed to the above address and marked *ATTN: GAPDMP*)

Patient Information Request Authority

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	**Driver's License Number**		**Date of Birth (MM/DD/YYYY)**
Reporting Period	**From**		**To**

_____ _____
Patient Signature Date

Office Use: Date Received: By: Date Returned: By:

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.

_____