



The Commonwealth of Massachusetts
 Department of Public Health, Bureau of Health Professions Licensure
 Prescription Monitoring Program
 250 Washington Street, Boston, MA 02108-4619
 Phone: 617-753-7310 Fax: 617-973-0985 Email: mapmp.dph@mass.gov

Third Party Data Request Form Prescription Monitoring Program (PMP)

FIPA (Fair Information Practices Act. M.G.L. c. 66A) authorizes a person to request the data of another person when a parent or guardian requests the data of a minor child, when the requestor has the data subject’s (Patient’s) power of attorney, or when the requestor has a court appointment as an estate administrator or executor for that person. If you do not have this kind of relationship to the person whose records you are requesting, you cannot gain access to records. If you are legal counsel seeking to make a data request, please contact the Program at mapmp.dph@mass.gov for guidance.

Checklist for required documentation:

- **If you are a parent or guardian requesting the PMP data of a minor:**
 - Copy of your government issue photo ID *and*
 - Copy of birth certificate of minor showing your relationship *or* Copy of guardianship papers showing your relation to the minor.

- **If you are requesting the PMP data of an adult:**
 - Copy of your government issue photo ID *and*
 - Copy of document proving power of attorney of the person whose data you are requesting *or*
 - Copy of document proving court appointment as personal representative, estate administrator, or executor for the person whose data you are requesting.

Instructions for completing form:

- All sections must be completed below. Incomplete Data Request forms will not be processed.
- Request form must be signed and dated.
- Along with required documents noted above, completed form must be faxed to 617-973-0985 or mailed to the Massachusetts Prescription Monitoring Program at 250 Washington Street, 3rd floor, Boston, MA 02108-4619. **Please do not email.**

Section I

Requestor’s First Name:		Requestor’s Last Name:	
Street Address:			
City/Town:		State:	Zip Code:
Contact Phone:		Email Address:	

Section II

Patient’s First Name:	Patient’s Last Name:
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Please see here for more information on the Massachusetts PMP: <https://www.mass.gov/orgs/prescription-monitoring-program>.

Patient's Date of Birth:	Patient's Last Known City and State of Residence:
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Reason For PMP Data request:

Please select the type of PMP data you are requesting and date range below:

<input type="checkbox"/> Patient's prescription history	Dates:	From		to	
<input type="checkbox"/> Who searched the patient's prescription records	Dates:	From		to	

How do you want the Department to return the requested information?

- Electronically sent via secure file transfer to email address Section I (preferred) Mailed to the address in Section I

Your Signature _____ **Date** _____