NEVADA STATE BOARD OF PHARMACY

NEVADA PRESCRIPTION MONITORING PROGRAM

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Authorization to Release Patient Utilization Report

The Nevada Prescription Monitoring Program (PMP) may only release a patient utilization report to the patient or the patient's attorney pursuant to NRS 453.164(8)(a) and NAC 453.088.

Patient Information

Patient's Full Name	Date of Birth		Phone Number
Street Address	City	State	Zip Code
Other Names Patient May Have Used	Patient's/Patient's Attorney's Email Address (Where the Report Will Be Sent)		
Range of dates requested for the Report (**Up To A Maximum of Three Prior Years**): From:	(DD/MM./YYYY) to		(DD/MM/YYYY).

Certifications

THIS AUTHORIZATION MUST BE EXECUTED BY THE PATIENT AND NOTARIZED

1. I understand that data in the PMP is Protected Health Information (PHI) as defined in 45 C.F.R. § 160.103 and protected from unauthorized use or disclosure under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. 45 CFR Part 160 and Part 164, Subparts A and E. Data in the PMP is also confidential and protected from unauthorized use or disclosure under state law. NRS 453.164(8).
2. I understand that data in the PMP is provided to the PMP by third-party entities that dispense controlled substances. Since the PMP does not maintain legal custody or control of the records of these third-party entities, and does not audit or verify the data provided, the PMP cannot certify that the data is accurate.
3. I hereby waive, discharge and hold harmless the Nevada State Board of Pharmacy and the PMP from any and all liability arising out of the release of the patient utilization report as authorized herein.
4. This authorization is valid for six months from the date of the signature below.

Patient Signature **Date**

FOR NOTARY USE ONLY

State of _____

County of _____

On this _____ day of _____ 20_____

_____
personally appeared before me and proved to me through satisfactory evidence of identification to be the person whose name is signed on the preceding document in my presence.

_____ _____
Notary Public **My Commission Expires**

IF SUBMITTED BY THE PATIENT'S ATTORNEY EXECUTE BELOW:

I declare under penalty of perjury that I represent the patient named herein and submit this authorization with the patient's consent and in the course of representation.

Attorney's Printed Name, Signature **State and Bar#** **Date**

***** ALL RELEASE FORMS MUST BE SUBMITTED TO PMPADMIN@PHARMACY.NV.GOV *****