VERMONT DEPARTMENT OF HEALTH	**Vermont Prescription Monitoring System** **Board of Medical Practice** **Request for Disclosure of Information Form** **{Secure Fax Number} 802-652-2019**
Name of Requester	***Email Address***
Telephone Number	***BMP Case Number***
I certify that the request is pursuant to a bona fide specific investigation identified by the BMP Case Number above and that I am duly designated by the Board of Medical Practice to make the request; and that the information requested is the minimum necessary to accomplish the intended purpose of the request: _____ _____ **Requestor's Signature** **Date**	

REQUEST PARAMETERS

☐ ***1. Information Requested about Prescriptions Written by a Licensee***

Name and Practice Address of Licensee	***DEA Number (if applicable)*** _____

☐ ***2. Information Requested about Prescriptions Written for the Named Individual(s)***

3. **REQUIRED:** ***Specific time period to be covered in report: From __/__/__ through __/__/__ (MM/DD/YY)***

☐ ***4. Information can be limited to the following drug(s)***

_____ _____ _____

For VPMS office use only	
Date Received	**Date of Action**

BMP Case Number: _____

Report to include the following information: (Please check)

_____ ***Information about a Licensee's use of the VPMS: Licensee***_____

_____ ***Is this licensee registered with the VPMS?***

_____ ***If yes, do they have delegates? If yes, please name***_____

_____ ***Number of searches by licensee during the period*** _____ ***to*** _____

_____ ***Number of searches by delegate during the period*** _____ ***to*** _____

_____ ***The name of the drug dispensed***

_____ ***The National Drug Code number for the drug and dosage dispensed***

_____ ***The date dispensed***

_____ ***The quantity and dosage dispensed***

_____ ***The number of days' supply dispensed***

_____ ***The number of refills prescribed***

_____ ***The prescriber's name***

_____ ***The prescriber's DEA number, including suffix if applicable***

_____ ***Pharmacy name and location (or specific pharmacy name/location:***_____***)***

_____ ***De-identified patient information (Example: Patient 1, Patient 2, and Patient 3)***

_____ ***De-identified patient age information***

_____ ***We hereby request that the information be provided with all of the available patient identifying information. The information requested is the minimum necessary to accomplish the intended purpose of this investigation.***

Signature of the Executive Director:_____

Notes:_____

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