| VERMONT DEPARTMENT OF HEALTH | **Vermont Prescription Monitoring System**<br>**Office of Professional Regulation**<br>**Request for Disclosure of Information Form**<br><br>**Secure Fax Number} 802-652-2019** |
|---|---|
| ***Name of Requester*** | ***Email Address*** |
| ***Telephone Number*** | ***Case Number*** |
| I certify that the request is pursuant to a bona fide specific investigation identified by the Case Number above and that I am duly designated by the Office of Professional Regulation to make the request; and that the information requested is the minimum necessary to accomplish the intended purpose of the request:<br><br>_____ **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)***<br><br>_____ |
|---|---|

☐ ***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)***

| |
|---|
| _____<br>_____<br>_____ |

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

***Case Number: _____***

***<u>Report to include the following information: (Please check)</u>***

_____ ***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 Chief Investigator:_____***

***Notes:_____***

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