VERMONT

Vermont Prescription Monitoring Program
[phone] 802-652-4147
[email] ahs.vdhvpms@vermont.gov
[web] https://www.healthvermont.gov/vpms

Division of Health Statistics and Informatics
Department of Health

VPMS Patient Prescription History Request

Please complete the information below. This form must be notarized, scanned and emailed securely to ahs.vdhvpms@vermont.gov. Please contact the program with any questions.

Full Name of Patient (First Name, Middle Name, Last Name, Suffix)	**Patient's Date of Birth**
Phone Number	**Email Address**
Mailing Address	**Physical Address (if different from mailing)**
Start Date for Prescription History Report	**End Date for Prescription History Report**
State Driver's License # or ID Card #:	**I would like:** ☐ Prescription History ☐ Access Audit Trails
I would like to receive my record (check one): ☐ Mail ☐ Email ☐ Picked up at:	
Other Comments:	

_____ _____

Patient Signature **Date**

STATE OF _____) COUNTY OF _____). On this ___ day of _____ , 20__, before me personally appeared _____, known to me to be the person who executed the foregoing instrument, and who, being duly sworn, acknowledged to me that they executed the same by their free act and deed.

_____ _____

Notary Signature **Notary Printed Name**