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PERSCRIPTION MONITORING PROGRAM NOTIFICATION

BY SIGNING THIS FORM, YOU CONFIRM THAT YOU HAVE BEEN NOTIFIED IN WRITING, THAT IF YOU RECEIVE A PERSCRTIPTION FOR A CONTROLLED SUBSTANCE (NARCOTIC DRUG) FROM EITHER OF OUR OFFICES AND FILL THAT PERSCRIPTION YOUR NAME AND OTHER PERSONAL INFORMATION WILL BE ENTERED INTO A SECURED STATE MAINTAINED PERSCRIOPTION DRUG MONITORING (PMP) DATABASE. STATE LAWS REQUIRES PHARMACIES TO REPORT INFORMATION ABOUT CONTROLLED SUBSTANCE PERSCRIPTIONS FILLED TO THAT STATE'S PMP AND DEPARTMENTS OF HEALTH.

THIS DATABASE IS USED TO PREVENT ABUSE OF CONTROLLED SUBSTANCES. THE DATABASE IS ONLY FOR NARCOTIC BASED CONTROLLED PERSCRIPTIONS ONLY. SUCH AS BUT NOT LIMITED TO PAINKILLERS, MUSCLE RELAXANTS AND STERIODS. IF YOU DO NOT WANT YOUR INFORMATION IN THE DATABASE, ASK FOR A NON-NARCOTIC DRUG PERSCRIPTION.

FOR MORE INFORMATION, PLEASE CONTACT YOUR STATE'S DEPRATMENT OF HEALTH.

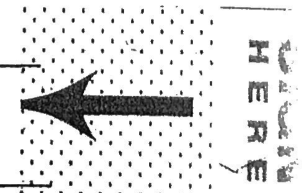
I HAVE READ AND UNDERSTAND THIS NOTIFICATION.

_______________ DATE

____________________________________ (SIGNATURE OF PATIENT / GUARDIAN)

IF THIS NOTIFICATION IS SIGNED BY A PERSONAL REPRESENTAIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

PERSONAL REPRESENTIVE NAME: ____________________________________



RELATIONSHIP TO PATIENT: ____________________________________