



SOUTH CAROLINA
DEPARTMENT OF
PUBLIC HEALTH

South Carolina Department of Public Health
Prescription Monitoring Program

P.O. Box 2046, West Columbia, SC 29171
Phone: (803) 896-0688

**REQUEST FOR INDIVIDUAL'S OWN CONTROLLED SUBSTANCES
REPORTING SYSTEM INFORMATION**

In accordance with S.C. Code Ann. § 44-53-1650(D)(2), "Drug Control may provide data in the prescription monitoring program to the following persons: ... an individual who requests the individual's own prescription monitoring information in accordance with procedures established pursuant to state law;".

PLEASE PRINT OR TYPE AND USE FULL NAME

Name (First, Middle, Last, Suffix (Jr., Sr., III))	Date of Birth
Street Address	City, State, Zip Code
Area Code and Telephone Number	Email Address

Specific time period to be covered in report

A prescription history report provides an overview of prescription activity over time. There may be a delay of up to 72 hours from the time a prescription is dispensed by a pharmacy or prescriber until the data is available in the Prescription Monitoring Program (PMP) system. The requested information is based on the search criteria utilized and the data entered by the dispensing entity. Hence, the PMP does not warrant any report to be accurate or complete. For more information about any prescription in a PMP report or to verify a prescription, contact the dispensing pharmacy or prescriber.

Individual's Signature: _____ **Date:** _____

Subscribed and sworn to before me in the County of _____,

State of: _____ this _____ day of _____, 20____.

Notary Public Seal

NOTARY PUBLIC

My Commission expires: _____

Mail the following items to the SC Prescription Monitoring Program at the address above:

- ***Notarized Individual's Own Controlled Substance Request Form***
- ***Copy of Current Government Issued photo Identification ***ID Address must match address on this form.***

Pursuant to S.C. Code Ann. § 44-53-1680(B), "A person or persons authorized to have prescription monitoring information pursuant to this article who knowingly discloses this information in violation of this article is guilty of a felony and, upon conviction, must be fined not more than ten thousand dollars or imprisoned not more than ten years, or both."

FOR PMP USE ONLY

Date Received	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	Signature	Date of Action
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Instructions for Completing 2000-ENG-DPH

PURPOSE: This form is to comply with the SC Prescription Monitoring Act SC 44-53-1650 D(2) where an individual may request a copy of the individual's own prescription monitoring program information.

AUDIENCE: The individual requesting a copy of their own prescription monitoring program information.

INSTRUCTIONS: The person completing the form should be the individual. The form must be filled out entirely, notarized and mailed to the address listed on the top of the form, along with a copy of the driver's license of the individual. The address on the driver's license must match the address on the individual's request form.

OFFICE MECHANICS & FILING: The form is filed and stored within the department area. This form is maintained by retention schedule 17639, Prescription Monitoring Program Patient Files. Once the 6-year retention period has been met and quality review has been completed, an ARM-11 destruction request should be submitted and approved prior to disposal of the original form.