



**Kansas Prescription Monitoring Program**

Kansas Board of Pharmacy  
800 SW Jackson, Room 1414  
Topeka, KS 66612  
Telephone: (785) 296-4056  
Fax: (785) 296-8420  
Email: pharmacy@pharmacy.ks.gov

**Prescriber Request for Discretionary Disclosure of Information from the Prescription Monitoring Program**

A prescriber may obtain a report listing all prescription monitoring program information that pertains to the prescriber directly from the Kansas Board of Pharmacy. **All required fields must be filled out and it must be signed in front of a Notary Public.** The form can be mailed, emailed, or faxed.

Last Name\* \_\_\_\_\_ Street Address\* \_\_\_\_\_  
First Name\* \_\_\_\_\_ City\* \_\_\_\_\_  
Middle Initial \_\_\_\_\_ Suffix \_\_\_\_\_ State\* \_\_\_\_\_ Zip\* \_\_\_\_\_  
Date of Birth\* \_\_\_\_\_ Phone\* \_\_\_\_\_  
DEA Number\* \_\_\_\_\_ Email\* \_\_\_\_\_

Report Timeframe\* (Data goes back to 7/1/10) \_\_\_\_\_

I certify that I am the person named above, that I am entitled to request my own controlled substance prescribing history report, and that it will be provided to me in the following manner:

- Email at the address provided above or
- Mailed via the U.S. Postal service at the address above

Signature\* \_\_\_\_\_ Print Name\* \_\_\_\_\_  
*\* Required field*

**NOTARY PUBLIC USE ONLY**

Subscribed and sworn before me in the County of \_\_\_\_\_, State of \_\_\_\_\_,  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

NOTARY PUBLIC \_\_\_\_\_

My Commission expires \_\_\_\_\_

**OFFICE USE ONLY**

Received by \_\_\_\_\_ Approved on \_\_\_\_\_ Denied on \_\_\_\_\_ Sent on \_\_\_\_\_