



**DEPARTMENT OF HEALTH
TENNESSEE BOARD OF PHARMACY
Controlled Substance Database Administrator
227 FRENCH LANDING, SUITE 300
NASHVILLE, TENNESSEE 37243
(615) 253-1305 OR FAX (615) 253-8782**

PATIENT RELEASE OF INFORMATION REQUEST

Please provide the information requested below. (Print or Type)

Patient Information:

Full Name of Patient:	Maiden Name:
Street Address:	AKA:
City:	State:
Zip Code:	Telephone Number: ()
Social Security Number:	Birth date:

Specific Time Period to be covered in report:

Start Date:	End Date:
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Requestor Information

Name of Person Information will be released to:	Street Address:
City:	State:
Zip Code:	Telephone Number: ()

This authorizes the above named person to request and receive from the Tennessee Controlled Substance Monitoring Database any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient named above during the time frame listed.

I understand that this authorization permits the disclosure of confidential health care records to the person named above. There is a potential for any information disclosed, pursuant to this authorization, to be subject to re-disclosure as permitted or required by law.

I understand that, if not previously revoked, this consent will expire one (1) year after the date of my signature unless otherwise specified.

I, _____, do solemnly swear and affirm that I have personally completed this form, and that the information in the foregoing paragraphs is true and correct to the best of my knowledge.

(Signature of Applicant)

Sworn to and subscribed before me this _____ day of _____ 20 ____ .

My Commission expires _____ .

(Notary Public)

For Department Use Only		Director of Designee Signature	Date of Action
For Department Use Only Date Received	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved		