How to Make a Law Enforcement Request

Please mail or fax a signed request to:

Prescription Monitoring Program
401 N. 4th St.
Springfield, IL 62702

Phone: 217-524-1311
Fax: 217-557-7975

*A PMP staff member will e-mail the results in an excel spreadsheet.

Please provide the following information, submitted on requesting agency letterhead:

Requester Information: Requester Name, Phone Number, E-mail address, Office address, Signature

For a Patient Request: Include the first and last name, date of birth, address and any aliases

For a Prescriber Request: Include the first and last name, prescriber DEA number and Prescriber office address

For a Dispenser Request: Include the name of dispenser, dispenser DEA number and dispenser address

Please copy the form below and paste it into the request:

<table>
<thead>
<tr>
<th>Dates For requested Information From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Illinois PMP releases a maximum of two years worth of data from date requested.</td>
<td></td>
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</table>

Case Number: ________________________

Demonstrate that a State or Federal Violation involving a Controlled Substance has occurred [570/318 (e)(1)] by prescriber, patient or pharmacy:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Demonstrate that the requested information is reasonably related to the investigation, adjudication, or prosecutor of the violation described above [570/318 (e)(2)], especially how patient specific information fits into the overall investigation and is not part of a phishing trip:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Attach copies of any other Information such as warrants or subpoenas.

I ___________________________ certify that I am authorized to receive this confidential patient information and this information will only be disclosed for use as evidence under the following circumstances and then only to a law enforcement officer or an attorney from the office of the Attorney General [570/318]:

(1) A proceeding under any State or federal law that involves a controlled substance [570/318 (h)(1)]

(2) A criminal proceeding or a proceeding in a juvenile court that involves a controlled substance [570/318 (h)(2)]

PMP Use Only
Date Received: ___________________ Date Released from PMP: ___________________