



For DPS Use Only

DOCTOR / PATIENT REQUEST OF INFORMATION

REGISTRANT			
Title			
Name			
DPS Registration Number		Expiration Date	
DEA Registration Number		Expiration Date	
Board License Number		Expiration Date	
Address			
City	State	ZIP Code:	County:
Phone		Fax	

SUBJECT OF REQUEST			
Last Name	First Name	Middle Name	Date Of Birth
Other Name Variations (list below)			
Last Name	First Name	Middle Name	Date Of Birth
Last Name	First Name	Middle Name	Date Of Birth
Identifying Numbers			
Driver License		DPS Registration Number	
Social Security Number		DEA Registration Number	
Other		Board License Number	
List all address possibilities			
Address	City	State	ZIP
Address	City	State	ZIP
Address	City	State	ZIP

TYPE OF REQUEST (please check one)		
<input type="radio"/> Prescribing History	<input type="radio"/> Dispensing History	<input type="radio"/> Patient History
Date Range From	To	<i>*Most recent three months will be provided</i>

PURPOSE OF REQUEST

I certify the information requested is in compliance with [Texas Health & Safety Code §481.076](#).

Original Signature of REGISTRANT (No Stamped Signatures) _____ Date: _____

Complete all applicable information and send via:

Email
RSDCriminal@dps.texas.gov



Mail
Texas Prescription Program
P.O. Box 4087, Austin, Texas 78773-0439



FAX
(512) 424-5373

Prescription Access in Texas
www.TexasPATX.com