



Florida's Prescription Drug Monitoring Program

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Authorization for Impaired Practitioner Consultant Access

Section 893.055(7)(c)5., Florida Statutes (F.S.), authorizes an impaired practitioner consultant (IPC), who is retained by the Department of Health under section 456.076, F.S., to review information in the E-FORCSE database regarding an impaired practitioner program participant or referral who has agreed in writing to the IPC's access and review of the information.

Rule 64K-1.003(5)(e), Florida Administrative Code, requires the person referred to or participating in the approved impaired practitioner program provide written authorization in order for an IPC to access information in the database. The referred or participating person shall use this form to provide this authorization.

FORM INSTRUCTIONS: This is an Adobe fillable form. Once complete, the person referred to or participating in the approved impaired practitioner program must sign and date the form. The form must also be signed by the IPC who is requesting access to the information. This form must be attached to the recipient query submitted electronically through the E-FORCSE secure web portal, as described in the Training Guide for Impaired Practitioner Consultants. (NOTE: Authorization for impaired practitioner consultant access is not necessary to be evaluated or monitored in the impaired practitioner program.)

Person Referred to IPC Authorization to Request Information					
Last Name [REDACTED]		First Name [REDACTED]		Date of Birth (MM/DD/YYYY) [REDACTED]	
Address [REDACTED]			City [REDACTED]	State [REDACTED]	Zipcode [REDACTED]
Telephone Number [REDACTED]		Dispensed Start Date (MM/DD/YYYY) [REDACTED]		Dispensed End Date (MM/DD/YYYY) [REDACTED]	
_____ Patient Signature _____ Date					
This authorization may be rescinded in writing at any time.					
_____ IPC Authorized User Signature _____ Date					
Program Participant in IPC Authorization to Request Information					
Last Name		First Name		Date of Birth (MM/DD/YYYY)	
Address			City	State	Zipcode
Telephone Number	Dispensed Start Date	Dispensed End Date	Monitoring Start Date	Monitoring End Date	
_____ Patient Signature _____ Date					
This authorization may be rescinded in writing at any time.					
_____ IPC Authorized User Signature _____ Date					