



Patient Activity Report (PAR)

Please complete the following information by typing or printing in the required fields.

PHYSICIAN INFORMATION			
Physician DEA No.:		License No.:	
Physician Name (As it Appears on your DEA Certificate)			
Physician Address			
	City:	State:	Zip Code:
Telephone No.:		Fax No.:	

PATIENT INFORMATION			
Last Name		First Name	
AKA (Also Known As)		Maiden Name	
Patient Address			
	City:	State:	Zip Code:
Telephone No.:			
Social Security No.:			Date of Birth

ADDITIONAL COMMENTS OR INFORMATION

AUTHORIZATION
<p>By signing below, I certify that I am a licensed health care practitioner eligible to obtain controlled substance history dispensed to the patient in my care identified above, based on data contained in the Controlled Substance Utilization Review and Evaluation System (CURES). I understand that any request for, or release of a controlled substance history shall be made in accordance with Department of Justice guidelines, that the history shall be considered medical information subject to the provisions of the Confidentiality of Medical Information Act (Civil Code §§ 56 et seq.)</p> <p style="text-align: center;">Please FAX your request to (916) 319-9448 Or mail to: California Department of Justice, P.O. Box 160447, Sacramento, CA 95816</p> <p>Physician Signature _____ Date _____</p>

For Department of Justice Use Only	Date Received Comments	Date Completed	Initials
---	-------------------------------	----------------	----------