APPOINTED PHARMACY CONSENT

SUBOXONE® (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet
SUBUTEX® (buprenorphine HCl) sublingual tablet

I ____ do hereby: (**MD check all that apply**)
Patient Name (Print)

☐ Authorize _________________________________ at the above address to disclose my treatment for opioid
Physician Name (Print)

dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy.

☐ Agree to purchase all SUBOXONE, SUBUTEX, and any other medications related to my treatment from the pharmacy specified below.

☐ Agree not to use any pharmacy other than the one specified below for the duration of my treatment with the physician specified above, unless specific arrangements have been made with the physician.

☐ Agree to make payment arrangements with the pharmacy specified below *in advance* of treatment, so that my buprenorphine prescriptions can be filled and either delivered to the office addressed given above or picked-up by employees of the same.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_________________________________ __________
Patient Signature Date

_________________________________ _________________________________ __________
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_________________________________ _________________________________ __________
Witness Signature Witness Name (Print) Date

Appointed Pharmacy: Name_________________________________ Phone______________________

Address____

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol and drug dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol or drug dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.