APPOINTED PHARMACY CONSENT

(buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet or film
(buprenorphine HCl) sublingual tablet, naltrexone (oral or extended-release injectable)

I_____ do hereby: (**check all that apply**)
Patient Name (Print)

☐ Authorize_____at the above address to disclose my treatment for opioid use disorder 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/naloxone prescriptions directly to the pharmacy.

☐ Agree to purchase all buprenorphine/naloxone, 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/naloxone prescriptions can be filled and either delivered to the physician's office address 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 use disorder 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 provider specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or substance use disorder treatment. 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.

_____

Signature of patient Date

Signature of parent/guardian/authorized signer (if applicable) Date

Signature of witness Date

APPOINTED PHARMACY:

NAME: PHONE:

ADDRESS:

CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

THE CONFIDENTIALITY OF SUBSTANCE USE DISORDER 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 HAVING OR HAVING HAD A SUBSTANCE USE DISORDER 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. THE REPORT OF ANY VIOLATION OF THESE REGULATIONS MAY BE DIRECTED TO THE ATTORNEY GENERAL FOR YOUR STATE.

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 THE APPROPRIATE STATE OR LOCAL AUTHORITIES.

After completion, scan form into patient record and provide a copy to the patient.