Maranacook Family Health Care

APPOINTED PHARMACY CONSENT

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

I _____ do hereby: (**MD check all that apply**)

- ❑ Authorize _____ at the above address to disclose my treatment for opioid 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 allow pharmacist to contact physician listed above to discuss my treatment if necessary 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.
- ❑ Agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary 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.
- ❑ Authorize _____ at the above address to disclose my treatment for opioid dependence to employees of the pharmacy

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	

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