APPOINTED PHARMACY CONSENT

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

I, _____, do hereby:

□ Authorize **Valery D. Tarasenko, MD,** 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.

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 & Time_____

Parent/Guardian Signature: _____
Parent/Guardian Name (Print): _____

Witness Name: Date:

Appointed Pharmacy: **FAX:**

PATIENT TREATMENT AGREEMENT

Patient Name: _____ **Date:** _____

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.

2. I agree to adhere to the payment policy outlined by this office.

3. I agree to conduct myself in a courteous manner in the doctor's office.

4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.

6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.

7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.

8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.

9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.

10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®* or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).

11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.

12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.

13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).

14. I agree to provide random urine samples and have my doctor test my blood alcohol level.

15. I understand that violations of the above may be grounds for termination of treatment.

Patient Signature _____ Date & Time _____

Parent/Guardian Signature _____ Parent/Guardian Name (Print) _____

Witness Name _____ Date: ____

TELEPHONE APPOINTMENT REMINDER CONSENT

I, _____, give Valery D. Tarasenko, MD and members of his staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):

□ Home

□ Work

□ Cell

Yes, this office may leave (check all that apply):

□ Voice mail at my Home □ Voice mail at my Work □ Voice mail on my Cell

□ Messages with people at my Home □ Messages with people at my Work

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 on 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.

_____ _____

Patient Signature Date

_____

Parent/Guardian Signature Parent/Guardian Name (Print)

Witness Name Date:

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I,_____, authorize Dr. Valery D. Tarasenko at the above address to:

□ Receive my medical history information from the following physicians:

(name, address) _____

□ Receive my treatment records from the following therapist:

Therapist (name, address) _____

□ Release my treatment information/records to the following healthcare professional:

(name, address) _____

□ Release my treatment information to the health insurance company listed below for billing purpose:

Insurance Provider (name, address) _____

This information is for the following purposes (any other use is prohibited): _____

_____

_____

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 by the physician specified above unless I withdraw my consent during treatment.

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 & Time**

_____ _____

Parent/Guardian Signature **Parent/Guardian Name (Print) Date**

Witness Signature **Witness Name /Date**

METHADONE TRANSFER CONSENT

I , _____, authorize **Valery D. Tarasenko, MD,** practicing at the above address to disclose my treatment for opioid dependence to the outpatient treatment program specified below in order to obtain my medical history, methadone treatment, and any other of my patient information pertinent to the office-based treatment with buprenorphine. I understand that the physician mentioned above may need to discuss my medical and treatment history with the physicians and other staff at the outpatient treatment program specified below.

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 on 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)

Witness Name Date

Outpatient treatment program: 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.