Cornerstone Behavioral Healthcare Acehelosu, a division of Cornerstone

Pharmacy Consent Form

Pharmacy Consent Form for Buprenorphine Treatment

By signing this Appointed Pharmacy Consent Form, the patient authorizes a physician to disclose to the pharmacy that he or she is being treated for opioid dependence; the pharmacy is also authorized to contact the physician to discuss treatment.

Client Name (printed):	
Authorized Physician Name:	
Pharmacy Name:	
Pharmacy Address & Phone Number:	
Check all that apply:	
	The above named physician has permission to disclose clients treatment for opioid dependence to employees of the pharmacy specified above. 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.
	The client agrees 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 or picked-up by employees of the same.

- I understand that I may withdraw this consent at any time, either verbally or in writing expect 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.

Client Signature	Date
Parent/Guardian Signature	Date
Witness Signature	Date