UPDATED INFORMED CONSENT TO PARTICIPATE IN BUPRENORPHINE TREATMENT

Patient Name: ____ Date: ____/_____/______

I authorize and give voluntary consent to use buprenorphine products to treat my opioid use disorder. Treatment procedures have been explained to me, and I understand that I should take my medication at the schedule determined by the program prescriber, or his/her designee, in accordance with federal and state regulations.

I understand there are other treatments for opioid use disorder such as naltrexone, methadone, abstinence and behavioral health strategies. My preference for treatment is the use of buprenorphine products.

I understand that, like all other medications, buprenorphine can be harmful if not taken as prescribed.

It has been explained to me that I must safeguard these medications and not share them with anyone because they can be fatal to children and adults if taken without medical supervision.

I also understand that buprenorphine can produce physical opioid dependence.

Like all medications, they may have side effects. Possible side effects, as well as alternative treatments and their risks and benefits, have been explained to me.

I understand that it's important for me to inform any medical and psychiatric provider who may treat me that I am enrolled in an opioid treatment program. In this way, the provider will be aware of all the medications I am taking, can provide the best possible care, and can avoid prescribing medications that might affect my treatment with buprenorphine or my recovery.

____ _____/_____/_____

Signature Date

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