S.C.A.N.

Change is beautiful

Appointed Pharmacy Consent

SUBOXONE (bupreorphine HCl/naloxone HC1 dihydrate) sublingual tablet
SUBUTEX Cbupreorphine H CI) sublingual tablet

I_____do hereby

Authorize Dr. Keene and SuboxCAN at 12409 W. Indian School Rd Avondale, AZ 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 bupreorphine prescriptions directly to the pharmacy.

Agree to purchase all SUBOXONE, SUBTEX 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.

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 physicians specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physicians specified above are otherwise notified by me.

I understand that the records to be released may contain information pertaining to the psychiatric treatment and/or treatment for alcohol and /or drug dependence. These records may also contain confidential information about communicable diseases including HIVCAIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 C42 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_____

Appointed Pharmacy:

Name_____ Phone_____