Opioid Medication Management Agreement

Date: _____

Patient Name: _____

Patient ID: _____

Dear [Patient's Name],

This agreement outlines the responsibilities of both you and your healthcare provider regarding the use of opioid medications for pain management. By signing this agreement, you acknowledge the risks and benefits of opioid therapy and agree to adhere to the terms outlined below:

1. You agree to take the medication exactly as prescribed.
2. You will not share your medications with anyone else.
3. You will not seek opioid medications from any other provider without informing us.
4. You agree to regular follow-up appointments to monitor your treatment.
5. You understand the risks of addiction and agree to communicate any concerns with your provider.

Please read and indicate your agreement by signing below:

_____

Patient Signature

_____

Provider Signature

Thank you for your cooperation.

Sincerely,

[Healthcare Provider's Name]

[Healthcare Facility Name]