Patient Opioid Monitoring Commitment

Date: [Insert Date]

To: [Patient's Name]

[Patient's Address]

Dear [Patient's Name],

We are committed to ensuring your safety and well-being as we manage your pain using opioid medication. This letter serves as a commitment agreement for your participation in our opioid monitoring program.

Agreement Terms

- I agree to take my medications exactly as prescribed by my healthcare provider.
- I will not share my medication with anyone else.
- I understand the importance of regular follow-up appointments and will attend all scheduled visits.
- I will notify my healthcare provider immediately if I experience any side effects or concerns regarding my medication.
- I commit to random drug screenings if required by my healthcare provider.

By signing below, I acknowledge that I understand the terms of this commitment and agree to participate in the opioid monitoring program.

Patient Signature: _____

Date: _____

Thank you for your cooperation.

Sincerely,

[Provider's Name]

[Healthcare Institution Name]

[Contact Information]