Controlled Drug Use Contract

I _____ acknowledge that I take federally controlled medications prescribed by _____. I understand that these medications can be highly addictive. I take these medications under the following conditions.

I give my permission for any medical provider or representative of Burlington Family Practice to share information regarding my use of controlled drugs to any law enforcement representative, pharmacy, or healthcare provider at any time without my notification.

I agree to allow Burlington Family Practice to obtain any information regarding my use of controlled substances from any health care provider or pharmacy.

I only take controlled substances for medical conditions under treatment by a licensed medical provider.

I will not give, sell, or otherwise dispense the medication to anyone other than myself.

I will not consume illicit drugs, and consent to random drug testing to demonstrate compliance.

I will not seek similar controlled medications from other health care providers.

I will only take the medication as directed on the written prescription.

I will keep my medications in a secure location at all times.

All written refill prescriptions require 2 business days' advance notice before they will be ready.

Prescriptions will not be refilled except during normal business hours.

If my medication is lost or stolen, it will not be refilled early.

If I become psychologically dependent on the medication, I will seek treatment for drug dependence.

Violation of any of the above conditions may result in my termination from Burlington Family Practice and may result in my incarceration for prescription drug fraud prosecuted to the fullest extent of the law.

_____ _____

signature date

_____ _____

printed name date of birth