**SACRAMENTO COUNTY ADULT CORRECTIONAL HEALTH**
**CONSENT TO OPIOID USE DISORDER (OUD) TREATMENT**

I, _____, (printed name), agree to the following terms and conditions of opioid use disorder treatment:

- Comply with the treatment plan established by my providers including attending all clinic visits, spot urine drug screens, alcohol breathalyzers, cell checks, follow up lab work and attending counseling appointments. I understand that the terms of this contract are not limited to the signing provider, but all Adult Correctional Health providers.
- Understand that my substance use and medical history may be provided to existing or new substance use providers to allow continuity of medical care.

The provider may discontinue OUD treatment if any of the following occur:

- I am found diverting or cheeking medications.
- If I refuse medical follow-up including clinic visits, urine drug screens, and other testing or counseling appointments.
- I am found taking other illicit substances or taking other patients' medications.
- If my treatment is no longer medically indicated or I request to discontinue it, my OUD treatment may be reduced or discontinued.
- I am hostile or abusive to staff or other patients including demanding increases in the frequency or dosages of medication.
- If it is not medically indicated or jeopardizes my safety or the safety of others.

A provider has reviewed this form with me and answered my questions.

Signed by:

_____ _____
Patient Printed Name Provider Printed Name

_____ _____
Patient Signature Provider Signature

_____ _____
Date Date