**CONSENT AND RELEASE FORM**

**FOR WITHDRAWAL MANAGEMENT SERVICES**

Patient Label:

*affix here*

**By checking the boxes below and signing this consent form, I confirm that I understand and/or agree with the following statements:**

I understand that I have been diagnosed with an **Opioid Use Disorder**.

I understand that, according to current medical evidence, **the safest and greatest chance**

**of recovery from opioid use disorder** can be achieved by starting **opioid agonist treatment** with buprenorphine/naloxone or methadone (first-line agents). The recommended duration of **opioid agonist treatment** varies depending on individual needs and circumstances.

I understand that if I choose to proceed with **withdrawal management** (also known as **‘detox’**) without follow-up care, I have a **high risk of relapse**, and a **high risk of overdose** due to decreased tolerance to opioids. Overdose can cause severe harms including brain damage, coma, and death.

I understand that **withdrawal management alone is against medical advice**.

I have been given sufficient time and opportunity to ask questions about the information above, and have received satisfactory clarification and advice.

I fully release and discharge the physician and staff from any responsibility or liability for any losses, damages, or injuries I may suffer as a result of my decision not to go on opioid agonist treatment.

**I consent to undergo withdrawal management services to be provided by the physician and care team, and have opted not to pursue follow-up care at this time.**

Client Signature Date

Physician, Nurse, or Staff Name and Signature Date