Montgomery Family Medicine Associates
2415 Musgrove Road, Suite 105
Silver Spring, MD 20904
301-989-0193

ADDICTION MEDICINE AND/OR CONTROLLED SUBSTANCE DEPRESCRIBING: CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: _____

Street Address: _____

_____Phone Number: _____

I, the Patient, understand that in order to receive safe and effective Addiction Medicine and/or Controlled Substance Deprescribing care, which includes care related to my use of alcohol or other drugs, behavioral addictions, and/or physical dependence on a controlled substance medication (even if taken only as prescribed), care coordination is essential. I understand that Montgomery Family Medicine Associates (MFMA) will provide focused care related to my Addiction/Deprescribing needs. For all other medical issues, I agree to continue following with my same Primary Care Provider (PCP), as well as any Specialists to whom my PCP may refer me. I hereby authorize MFMA to discuss my Addiction Medicine care with my other health providers, as listed below. Discussion may include both verbal and written communication. I understand that, should I choose to decline to sign this form, MFMA may not be able to render services to me.

My Other Health Providers (leave blank if Patient has not received care from specified type of provider):

1. Primary Care Provider Name/Facility: _____
   Phone Number: _____ Fax Number: _____
2. Psychiatrist Name/Facility: _____
   Phone Number: _____ Fax Number: _____
3. Therapist Name/Facility: _____
   Phone Number: _____ Fax Number: _____
4. Pain Management Specialist Name/Facility: _____
   Phone Number: _____ Fax Number: _____
5. Other Provider who may Perform Surgery and/or Prescribe a Controlled Substance: Name/Facility:
   _____
   Phone Number: _____ Fax Number: _____
6. Alcohol/Drug Treatment Facility: _____
   Phone Number: _____ Fax Number: _____

_____ *My initials here indicate my understanding that this Authorization is valid for the duration of treatment at MFMA. If in future I wish to revoke it, I may not be able to continue to receive care at MFMA.*

Patient Signature: _____ Date: _____

Form last modified: 2/9/2026