

PRESCRIBING PHYSICIAN

Medical or Dental Medication

Re: _____ (Patient's Name)

To: The Honorable _____

It is my understanding that the above named patient is addicted to drugs and/or alcohol. The patient has informed me that he/she is under the supervision of the Harris County Community Supervision and Corrections Department (HCCSCD) and the Harris County Criminal Courts at Law. I understand that any drug relapse by this patient could result in a Court sanctions and possibly time served in the Harris County Jail. I am furnishing this information pursuant to a medical release executed by the patient authorizing me to provide this information to the Harris County Criminal Courts at Law and HCCSCD.

Please Initial and Complete the Appropriate Selection(s) Below

- I am a licensed physician in the State of Texas. The above named person is my patient, and I have seen him/her for the following medical reason(s) / complaint:

- I have am a licensed physician in the State of Texas. The above named person is my patient, and I made the following diagnosis in his / her case:

- I understand that the patient is an addict and currently in recovery. I understand that prescribing narcotic / addictive medication to this patient will jeopardize his / her recovery. I have determined, however, that non-narcotic / non-addictive medication would not be effective in the patient's treatment. Accordingly, I am prescribing the following narcotic / addictive medication(s) for the patient:

Prescription and Dosage Information: _____

Prescription and Dosage Information: _____

- I am prescribing the following non-narcotic/non-addictive medication(s):

Prescription and Dosage Information: _____

Prescription and Dosage Information: _____

Date Signed: _____ 20____.

Print Doctor's Name

Doctor's Signature

Name of Medical Facility	
Address	
City, State, Zip Code	
Phone Number	