DRUG / CONTROLLED SUBSTANCE TESTING CONCSENT FORM

I, _____, herby give my consent to authorize my medical provider Marshall Primary Care to conduct analysis test deemed necessary, at the providers discretion such as be compliant with the state regulations, to determine the absence or the presence of controlled substances, both prescription and recreational substances. Testing will be performed though urine collection.

If you are called into the office for a pill count, you will have by the end of the business day to report to the office. If you fail to do so this will result in the termination of my future prescriptions of any controlled substance.

I further understand that a positive test, refusal to authorize this form, refusal to take a test or failure to produce a specimen, may also result in termination of primary care agreement and cancellation of controlled prescriptions. If, requested, the urine can be sent out to a 3rd party lab (Compass laboratory/ LabWorks) for confirmation. This policy exists to protect both the prescriber and the patient. We thank you for your understanding and cooperation.

Print Name: _____

Patient Signature: _____

Date: _____