

## Patient Consent for Drug Screening

I understand that my physician has requested that I be tested to determine the level of drug or metabolite in my body.

I further understand and agree that the testing will be performed in the physician's office and/or sent to an outside laboratory as needed, on a specimen of my urine that I provide for the purpose of this drug test.

I understand and agree that the outside laboratories used and my physician will maintain confidentiality of my urine drug test results.

I understand that the test results and interpretation will become part of my medical record. I understand that an insurance company may discover the results of this test by my informing them of this test or by obtaining a copy of my medical record from my physician.

I understand that any discrepancies between the results of the drug screening and the complete medication list I have provided may be considered a violation of my pain management agreement and result in actions by my physician.

I understand that I will be solely responsible for any financial balance to the outside laboratory and/or physicians office should the drug screening not be covered in part or in full by my insurance company.

All of the above have been discussed with and I have had the opportunity to have any questions answered that I have regarding the drug testing or my rights to privacy.

\_\_\_\_\_  
Patient Name (print)

\_\_\_\_\_  
Witness Name (print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date