TREASURE COAST Urgent Care

STUART | 1050 SE Monterey Rd. Suite 101 • Stuart, FL 34994 • **772-419-0560**
www.tcurgentcare.com | Secure Fax: 772-403-2379

DRUG AND ALCOHOL TESTING

AUTHORIZATION AND NOTICE

_____ _____ _____

Patient Name | Social Security No. | Today's Date

MALE ☐ FEMALE ☐ _____ _____

Date of Birth | Phone

_____

Address | City | State | Zip

** If patient **is UNDER THE AGE OF 18** – Please provide the following information **

_____ _____

Parent or Guardian Name | Relationship to Patient

Any email address obtained by Treasure Coast Urgent Care will be used to inform you about our healthcare services or to obtain feedback to improve our healthcare services. We will never share your email address with third parties for the purposes of advertising their services independently of Treasure Coast Urgent Care.

STOP HERE IF D.O.T. TEST

1. **Refusal.** I understand that I may refuse this test, however, my job, employment opportunity or Workers' Compensation coverage may be in jeopardy. (Please refer to your company's policy.)
2. **Testing, Reporting, Disposal.** I understand and consent that the urine, hair, blood and/or breath samples to be submitted by me at this center are to be tested here or at an approved laboratory for the presence of controlled substances and/or alcohol and I do hereby authorize Treasure Coast Urgent Care and others working with them to perform and report such tests as may be required by the authorizing company. I hereby authorize Treasure Coast Urgent Care and others working with them to dispose of any unused urine, hair, blood and/or breath samples given by me that are not expended in testing.
3. **Release of Liability.** I waive any claim I may have and do further agree, to indemnify and hold harmless Treasure Coast Urgent Care, and the agents or employees of this center or persons or entities working with this center from any loss, damage expense or other injury arising as a result of the testing procedures authorized here.
4. **Specimen.** I certify that I will provide only my specimen to the collector and that I have not altered it in any manner.
5. **Consent.** I certify that I understand my rights and the matters contained in this authorization and I further certify that I have executed this authorization of my own free will and accord.
6. **Florida Drug-Free Workplace.** If your company is participating in the Florida Drug-Free workplace program, they are required to comply with the Florida Workers Compensation Law – 440.102 and standards set by the Federal Agency for Health Care Administration You have the right to discuss prescription medications with the company designated medical review officer if needed within 5 days after receiving written notification from your employer. All discussions and results are held confidential as required by law. Please ask the collector for any additional information regarding this test. Please ask your company about any additional agreements relating to their drug testing program.

_____ _____

Patient/Guardian Signature | Date