

# Consent for Urine Drug Screening in Substance Abuse Treatment

## Patient Information

Full Name

Date of Birth

ID/Medical Record Number

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## Consent Statement

I acknowledge that as part of my substance abuse treatment, I may be required to provide urine specimens for drug screening. I understand that the results will be used to monitor my treatment progress and shared with my treatment providers.

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I have read and understand the above information.

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I voluntarily give my consent for urine drug screening as part of my treatment.

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## Signatures

Patient Signature

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Date

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Witness/Staff Signature

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Date

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