



**PSYCHIATRIC
CONSULTANTS
OF FLORIDA, LLC**

*SPECIALIZING IN ADULT, CHILD AND ADOLESCENT,
FORENSIC PSYCHIATRY AND ADDICTION MEDICINE*

3595 SHERIDAN STREET, SUITE 109
HOLLYWOOD, FLORIDA 33021

(954) 967-6776 TELEPHONE
(954) 272-7848 FAX

**DRUG AND/OR ALCOHOL TESTING CONSENT FORM
RANDOM DRUG AND/OR ALCOHOL CONSENT FORM**

I hereby agree, upon a request made under the drug/alcohol testing policy of **PSYCHIATRIC CONSULTANTS OF FLORIDA, LLC (PCF)**, to submit to a drug or alcohol test and to furnish a sample of my urine for analysis. I understand and agree that if I, at any time refuse to submit to a drug or alcohol test under company policy, or if I otherwise fail to cooperate with the testing procedures, I may be subject to immediate termination from the practice.

I understand that there is a collection fee of \$15.00

I further authorize and give full permission to have **PCF** send the specimen collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to **PCF**.

This authorization is valid for one year.

PRINT PATIENT NAME

PATIENT SIGNATURE

WITNESS

DATE

BOARD CERTIFIED BY THE
AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
DIPLOMATE OF THE
AMERICAN BOARD OF ADDICTION MEDICINE