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**CONSENT FOR TOXICOLOGY TESTING**

I am aware that it is the policy of the Odibo Medical Group to perform regular urine drug screens on patients who are prescribed controlled substances. Refusal to provide a urine sample will prevent the future prescribing of medications and/or dismissal from the Odibo Medical Group.

Therefore, I consent to provide a urine specimen at the request of my practitioner. In addition, I permit the Odibo Medical Group to contact any pharmacy, physician or hospital to specifically discuss my medications when they feel it is indicated.

I assign my insurance benefits (if any) and authorize insurance payments to be paid directly to the referring laboratory for the laboratory services ordered by my practitioner. I authorize my practitioner and my insurance company (if any) to release information to the referring laboratory to determine insurance benefits for any laboratory services ordered by my practitioner.

If I am a self-pay patient, I accept full responsibility for all charges associated with this testing.

I further authorize the release of test results to the providers of Odibo Medical Group.

Patient Name (Printed): \_\_\_\_\_

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

Date: \_\_\_\_\_