**DRUG TESTING AUTHORIZATION**

**DATE OF REQUEST:**

**INDIVIDUAL:**       **DOB:**

**ADDRESS:**       **PHONE:**

**PROVIDER**:

**MEDICATION LIST:**

**RESULTS:**

**SEND INVOICE TO:** Columbia County Health and Human Services

 Attn: Fiscal

 P.O. Box 136

 Portage, WI 53901

**AUTHORIZED BY:**

**VERIFIED BY TESTER**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_