DAVE YOST
OHIO ATTORNEY GENERAL

Ohio Peace Officer Training Commission
Office 800-346-7682

P.O. Box 309
London, OH 43140
www.OhioAttorneyGeneral.gov

Authorization for Use or Disclosure of Drug Screen Information

Applicant's Name: _____

Applicant's Date of Birth: _____

Commander: Thomas Wieczorek

Commander's Address: 11000 W Pleasant Valley Rd, Parma, OH 44130

I hereby consent to submit to a drug screen and to furnish a sample of my urine for analysis to a testing facility designated by the commander in order to be eligible to attend peace officer basic training.

I further authorize and give full permission to have the laboratory or other testing facility release any and all documentation relating to such screen to the above listed commander or designee. I further agree to and hereby authorize the release of the results of said tests to the commander, their designee, or the Ohio Peace Officer Training Commission (OPOTC).

I understand that my sample will be screened for the following substances and concentrations:

Initial test analyte	Initial test cutoff concentration	Confirmatory test analyte	Confirmatory test cutoff concentration
Marijuana metabolites	50 ng/mL	THCA	15 ng/mL
Cocaine metabolites	150 ng/mL	Benzoylecgonine	100 ng/mL
Codeine/Morphine	2,000 ng/mL	Codeine Morphine	2,000 ng/mL 2,000ng/mL
Hydrocodone/Hydromorphone	300 ng/ml	Hydrocodone Hydromorphone	100 ng/ml 100 ng/ml
Oxycodone/Oxymorphone	100 ng/ml	Oxycodone Oxymorphone	100 ng/ml 100 ng/ml
6-Acetylmorphine	10 ng/mL	6-Acetylmorphine	10 ng/mL
Phencyclidine	25 ng/mL	Phencyclidine	25 ng/mL
Amphetamine/Methamphetamine	500 ng/mL	Amphetamine Methamphetamine	250 ng/mL 250 ng/mL
MDMA/MDA	500 ng/ml	MDMA MDA	250 ng/ml 250 ng/ml

I understand that a positive test result, refusal to authorize the tests by signing this form, refusing to take the specified test(s), or failure to produce a specimen, may preclude me from attending this academy.

I understand that I must provide proof within 72 hours that I am taking a controlled substance as directed pursuant to a lawful prescription issued in my name if that substance causes a positive result.

I understand that the OPOTC certified school is not a covered entity and is not subject to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that there is a potential that information disclosed to the OPOTC certified school may be subjected to redisclosure by the OPOTC certified school, and not protected from such redisclosure by federal law or federal rule.

I understand that I may revoke this authorization in writing submitted at any time to the OPOTC certified school except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate two years from the date of my signature.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act and that I have not been coerced into signing this document.

Signature: _____ Date: _____