CONSENT FOR MEDICAL FORENSIC EXAM

☐ **I give consent for medical evaluation and treatment. I give consent for the collection of evidence for sexual assault. I understand I may withdraw my consent at any time for any portion of the exam.**

X_____
PATIENT INITIALS

Date:_____

☐ **I give consent for photo-documentation related to the sexual assault. I understand I may withdraw my consent at any time for any portion of the exam.**

X_____
PATIENT INITIALS

Date:_____

I consent and authorize_____ employed by _____ to conduct
Medical Provider and Title **Name of Institution**
a medical-forensic exam for the purposes of **evidence collection.**

X_____ _____
SIGNATURE OF PATIENT/PARENT/GUARDIAN IF PARENT/GUARDIAN, PRINT NAME & RELATIONSHIP

X_____ _____
SIGNATURE OF MEDICAL PROVIDER PRINTED NAME OF MEDICAL PROVIDER

RELEASE OF INFORMATION

☐ I authorize the release of documentation and evidence collected to law enforcement for purposes of:

☐ Investigation ☐ Storage Only

X_____ Date:_____
PATIENT INITIALS

FROM:		**TO:**	
Medical Facility:		Agency Name:	
Street Address:		Street Address:	
City/State/Zip:		City/State/Zip:	

X_____ _____
SIGNATURE OF PATIENT/PARENT/GUARDIAN IF PARENT/GUARDIAN, PRINT NAME & RELATIONSHIP

X_____ _____
SIGNATURE OF MEDICAL PROVIDER PRINTED NAME OF MEDICAL PROVIDER