WAIVER OF MEDICAL PRIVILEGE AND AUTHORIZATION FOR RELEASE OF MEDICAL AND LEGAL INFORMATION FOR VICTIMS OF ASSAULT

Immanuel St. Joseph's
Mayo Health System

1025 Marsh Street, P.O. Box 8673, Mankato, MN 56002-8673, Phone 507-625-4031

Patient's Name _____ Medical Record # _____

☐ *(Initials)* I hereby authorize this hospital, Immanuel St. Joseph's — Mayo Health System, to examine and treat me for any injury *(or disease)* sustained as a result of this assault. I also authorize Immanuel St. Joseph's to take any and all medical tests that may be necessary or helpful for treatment or for legal evidence and to photograph any injury or abnormality found.

☐ *(Initials)* 1. I also authorize Immanuel St. Joseph's to release all of the evidence found *(obtained)* and all of the information contained in the medical records concerning this assault examination and treatment to the law enforcement agencies that may be involved in investigating this assault or in prosecuting the assailant. I also request the law enforcement agencies to release evidence regarding my case to Immanuel St. Joseph's — Mayo Health System Sexual Assault Resource Team.

☐ *(Initials)* 2. I do not release my file or want to give a report to law enforcement at this time. If I change my mind I will contact law enforcement and sign a release to have my file and all evidence collected related to the assult released to the appropriate law enforcement agencies and sexual assault team. I do realize that the evidence will be stored at the hospital for 30 days and then destroyed.

☐ *(Initials)* 3. I decline the sexual assault exam. I do realize I have up to 72 hours to have the exam done.

I hereby waive all medical privilege in connection with such examination, treatment and evidence found, and I expressly authorize the use of such medical information in any subsequent criminal prosecution in the State or Federal Courts against the assailant.

I understand that this is not a routine medical checkup but a sexual assault evidentiary exam. The nurse doing the exam will not be held responsible for identifying, diagnosing or treating any existing medical problems I may have.

I understand that this waiver and release authorizes a complete medical/legal examination to be done and also authorizes releasing the records of that examination to the appropriate law enforcement agencies, but that nothing contained in this waiver and release obligates me to prosecute the assailant. I also understand that this waiver serves as a request for the appropriate law enforcement agencies or prosecuting authority to release investigative data regarding my case to Immanuel St. Joseph's — Mayo Health System Sexual Assualt Resource Team.

Signed *(Patient)* _____

Signed for _____ by _____

who is the *(Relationship)* _____ of the patient.

Date _____ Time _____

Witness _____ Date _____