_____ I understand I am entitled to have a forensic medical examination without reporting to law enforcement at the time of the examination.

_____ I have been informed of my right to a medical screening examination performed by qualified medical personnel to diagnose and treat unstable medical conditions regardless of my ability to pay for such an examination and/or treatment. At this time, I waive this right, realizing I assume all risks if I have an undiagnosed emergency medical condition. I also understand at anytime I can request such an examination or return to the emergency department for evaluation.

_____ I understand the forensic medical examination will be conducted by a sexual assault nurse examiner (SANE) for the purpose of injury identification and evidence collection.

_____ I understand and consent to photographing injuries, which may include the genital area. These photographs will be used for evaluation and treatment.

_____ I understand and consent that these photographs may be used for educational purposes and my identity will remain anonymous.

_____ I understand and consent to having blood and/or urine taken as part of the evidentiary collection process.

_____ I understand law enforcement will maintain custody of the evidence collection kit and my clothing (if applicable), and my identity will remain anonymous.

_____ I understand I have ( ) days to report the sex crime to the local law enforcement agency having jurisdiction, which is _____.

_____ I understand the (INSERT NAME OF NOTIFYING AGENCY) will notify me at my last know home address 6 months and 30 days prior to the destruction of the evidence collected.

_____ I understand it is my responsibility to notify the (INSERT NAME OF NOTIFYING AGENCY) of any changes in my address at (INSERT PHONE NUMBER OF AGENCY)

_____ I, the patient, who is at least 18 years of age, release the (INSERT NAME OF AGENCY) from any liability that may result from the release of this information to (INSERT NAME OF AGENCY)

_____ I have received a copy of this document.

Patient Signature: _____ Date: _____

SANE Signature: _____ Date: _____