

CONSENT FOR A FORENSIC EVALUATION

- I. I understand that a forensic evaluation can, with my consent, be conducted by a forensic nurse examiner to identify and preserve potential evidence of the assault. I understand that I may withdraw my consent at any time for any portion of the evaluation.
- II. I understand that this evaluation is for evidentiary and forensic purposes only and that any medical conditions will need to be addressed by the Emergency Department Physician or my primary care physician.
- III. I understand that the forensic evaluation may include history gathering, an assessment and evidence collection.
- IV. I understand that all licensed healthcare professionals are required under state law to report suspected child abuse and neglect, as well as adult abuse and neglect and that this will be done by hospital staff, if the evaluation warrants a report.

I give permission for the Forensic Nurse Examiners of _____ to perform a forensic evaluation of me. I certify that I have read, understand and agree to the conditions described above.

Signature of Patient or Legal Representative _____ **DATE** _____

If signed by legal representative, relationship to patient: _____

Signature of Witness: _____ **DATE** _____

CONSENT FOR PHOTOGRAPHY

- I. I understand that photographs, videotapes, digital or other images may be recorded to document my care for forensic purposes, and I consent to this. Like all evidence collected in this evaluation, these items may be used in criminal and civil legal proceedings. I understand that the above mentioned photographic images may include the genital and anal area.
- II. I understand that _____ Hospital will retain ownership rights to these photographs, videotapes, digital, or other images but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outline in the _____ Hospital policy. Images that identify me will be released only upon written authorization from me or my legal representative or unless disclosure is required by law, a court, or a legal process.

Signature of Patient or Legal Representative _____ **DATE** _____

If signed by legal representative, relationship to patient: _____

Signature of Witness: _____ **DATE** _____



CONSENT FOR USE OF PHOTOGRAPHY FOR EDUCATIONAL PURPOSES

- I. I hereby give my consent to have photographs, videotaped images, or other images made of myself or my family member. I understand that these images will contain **no** identifiable information or markers.
- II. I understand and agree that these images may be used by the Forensic Nurse Examiners of _____ Hospital for educational purposes.

Signature of Patient or Legal Representative _____ **DATE**

If signed by legal representative, relationship to patient: _____

Signature of Witness: _____ **DATE**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

- I. I hereby authorize _____ Hospital to disclose the following information from the health records of:

Patient Name: _____

Date of Birth: _____ Medical Record Number: _____

- II. Information to be disclosed:

- Complete Health Record
- Discharge Summary
- History and Physical Examination
- Consultation Reports
- Laboratory Tests
- X-ray or Imaging Reports
- Complete Forensic Record
- Photographs, videotapes, digital or other images
- Other (Please Specify) _____

_____(Initials) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for drug and alcohol abuse.

III. This information is to be disclosed to:

Person(s) to Receive Information: _____

For the Purpose (s): _____

IV. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____.

V. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to _____ Hospital. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

VI. I understand that after signing I will be given a copy of this authorization form, if requested. I understand that copying charges for my health information and for photographs, videotapes, digital or other images will be applied, according to the hospital policy.

Signature of Patient or Legal Representative _____ **DATE**

If signed by legal representative, relationship to patient: _____

Signature of Witness: _____ **DATE**