SEXUAL ASSAULT EXAM Consent Form

Hospital Label

Consent for Examination of Victims of Sexual Assault and For Release and Use of Medical and Legal Information

I authorize the (Hospital) ______________________ Provider/Nurse to examine and treat me at ______________________ (Hospital) on __________ (date) for injuries and/or conditions incurred as a result of a sexual assault that occurred on or about ______________ (date). I authorize the hospital staff to obtain any clinical samples and specimens and conduct any medical tests deemed necessary or helpful for treatment, legal evidence, and to take photographs of any injury or abnormality found.

The examination is not a routine medical exam. It is being performed in order to document, diagnose, and treat any injuries and possible conditions related to a sexual assault. The Provider/Nurse will not attempt to identify, diagnose, or treat any unrelated and/or pre-existing medical problems that you may have.

I understand that I may decline this examination or any part of it. I understand that once the exam begins, I may decline any portion of the exam and I must notify the person conducting the exam that I wish to stop the exam.

I authorize the hospital to disclose information gathered in connection with my medical forensic exam for the purpose of criminal and associated legal proceedings. These parties include: law enforcement (police), criminal laboratories, and prosecuting and defense attorneys. I understand this authorization does not obligate me to participate in the prosecution of the assailant. Information that may be disclosed: Evidence collected during this exam, protected health information obtained during this exam, photographs taken in connection with this exam and any other information gathered in connection with this examination and treatment. **Patient initials** ________

I authorize the Hospital to use samples collected, photographs taken, and information obtained during my sexual assault exam for educational purposes relating to the Hospital.

Signature: ______________________ Printed Name: ______________________

☐ Patient ☐ Parent ☐ Guardian

Date: ______________________ Time: ______________________

To be completed by Provider/Nurse:

I have fully discussed the procedure and the information included in our sexual assault protocol, which includes a description of the sexual assault exam as well as a description of the patient's options regarding consent to unrestricted release and restricted release of the sexual assault exam kit. The patient was given the opportunity to ask questions and receive information to their satisfaction.

Staff Signature: ______________________ Printed Name: ______________________

Date: ______________________ Time: ______________________

Declination of Consent:

Patient declined to consent to a sexual assault exam due to:

____

Signature: ______________________ Printed Name: ______________________

☐ Patient ☐ Parent ☐ Guardian

Staff Signature: ______________________ Printed Name: ______________________

Date: ______________________ Time: ______________________