

STEP 1

AUTHORIZATION AND DISCLOSURE FORM_[CL1]

Kit Number: _____
Date of Birth: _____
Date of Examination: _____
(Month/Day/Year)

Patient Label (top copy only)

Call made to local crisis center for an advocate to support patient Yes No *(This must be done with every case to support the patient and/or family)*

Hospital received permission to contact patient: By Telephone By Mail Permission Denied

Indicate which of the following will be released:

One sealed evidence collection kit containing evidence (including blood)
 Urine Sample for "Drug-Facilitated Sexual Assault" Test (**sealed in biohazard bag OUTSIDE KIT**)
 Evidence bags sealed outside of kit (examiner please indicate # _____ not including urine sample)

Evidence Bags	Article	Description
No. 1	_____	_____
No. 2	_____	_____
No. 3	_____	_____
No. 4	_____	_____

REPORTED CASES:
Person authorizing release of information is (check one): Patient Patient's Parent/Guardian Other _____
Purpose of the use and/or disclosure: Mutually share information for health and safety.

DISCLOSURE OF PROTECTED HEALTH INFORMATION/RECORD RELEASE

I hereby authorize _____ (Health Care Facility) to collect and transfer my evidence collection kit, forms, and evidence to the below listed law enforcement agency. I also authorize law enforcement to deliver my evidence collection kit, forms and any other evidence to the NH State Police Forensic Laboratory for analysis. I further authorize the use/disclosure of my individually identifiable health information as described below (which may include information concerning treatment for drug/alcohol abuse, mental health and HIV status, if applicable). I understand that if the recipient authorized to receive the information is not a covered entity, (eg. insurance company or health care provider) the disclosed information may no longer be protected by federal and state privacy regulations.

Do NOT sign below if completing an ANONYMOUS kit. Go to the bottom of the form.

I hereby authorize _____ to release the following information covering treatment
(Hospital/Record Holder)
given to me on _____ to _____.
(Month/Day/Year) (Law Enforcement Agency/DCYF)

Name of person authorizing release of information (please type or print): _____
(Last) (First) (Middle)

Patient Signature Date

ANONYMOUS CASES:
DISCLOSURE OF PROTECTED HEALTH INFORMATION/RECORD RELEASE

I hereby authorize _____ (Health Care Facility) to collect and **transfer** my evidence collection kit, forms and evidence bags to the above listed law enforcement agency. I also authorize law enforcement to deliver my evidence collection kit, forms and any other evidence to the NH State Police Forensic Laboratory. I understand that the law enforcement agency has **not** been given the right to view my record, or analyze the evidence, **and will not** be given that right except by my authority.

PATIENT SIGNATURE DATE

Witness/Examiner Signature Date