November 13, 2003

STATE OF NEW YORK

AUTHORIZATION FOR RELEASE OF DRUG FACILITATED SEXUAL ASSAULT SCREENING

I, _____ consent to the taking of blood and urine specimens for the purpose of identifying the presence of drugs as a part of this sexual assault exam. I understand that my samples will be turned over to a law enforcement officer and that information regarding the results of the screening may be released to the defense, prosecution and other law enforcement officials. I understand that testing the specimens may detect drugs that have been ingested voluntarily prior to this sexual assault, including, but not limited to recreational drugs. I understand that the results of this screening will become part of my medical record, and may be admissible as evidence in court.

_____ _____
Signature (Parent/Guardian if applicable) Witness

_____ _____
Date/Time Address

_____ _____ _____
Date of Birth Medical Record#

RECEIPT OF INFORMATION

I certify that I have received one sealed New York State Drug Facilitated Sexual Assault evidence kit.

Print the name of person receiving the kit _____

Signature of person
receiving the kit: _____ Date _____ Time _____

ID#/Shield#/Star#/Title: _____ Precinct/Command/District _____

Person receiving kit is representative of _____

Name of person releasing kit: _____ _____
Printed Name Signature

Distribute: Original to law enforcement
Copy to medical record
Copy to patient

DO NOT PLACE THIS FORM INTO THE SEALED KIT