Ohio Department of Health Consent For Exam, Photographs, and Release of Evidence

PAYMENT/BILLING OF TREATMENT

_____ I understand that I will not be charged for the antibiotics and evidence collection exam. Any other medications and medical treatment including but not limited to x-rays and blood work will be billed to me, my insurance or another named party for payment.

MEDICAL FORENSIC EXAM/EVIDENCE COLLECTION/PHOTO DOCUMENTATION

_____ I consent to the medical forensic exam. I understand that I can decline any portion of the exam or any portion of evidence collection process. I understand my choice of treatment steps during the exam will be reassessed frequently.

_____ I consent to the evidence collection during the forensic examination. I understand that I can decline any portion of the exam or any portion of evidence collection process. I understand my choice of treatment steps during the exam will be reassessed frequently.

_____ I consent to photo documentation, which may include my genitalia, body parts if injuries are present. I understand that I can decline any portion of photo documentation including photo documentation of my genitals.

_____ I consent to the medical forensic exam and photographs to be used in future educational presentations for forensic examiners.

_____ I consent to the release of all medical records and photographs to the appropriate law enforcement agency related to the sexual assault forensic examination.

REPORTING

every patient will initial this section (not specific to method of reporting)

_____I understand the hospital is legally required to report sexual assaults to law enforcement. My name and contact information will be given to law enforcement unless I choose to decline my name and contact information to be given. I understand that the hospital is legally required to report all abuse or suspected abuse of patients 17 years of age or younger to the Department of Children Services. For patients 17 years or younger, the hospital is required to send a letter to the parent or legal guardian notifying them of the exam. The sexual assault evidence collection kit and toxicology samples for drug-facilitated sexual assault will be given to law enforcement and may be tested at a crime lab.

Patients 18 years or older (Initial one) **indicates choice of the patient's method of reporting**

_____ I agree to speak to law enforcement. I understand that my name and contact information will be provided to law enforcement.

_____ I **DO NOT** agree to speak with law enforcement at this time. My name and contact information will be given to law enforcement. I understand that law enforcement **may attempt to contact me**. I understand that I am not obligated to participate in the investigation of this crime, but that law enforcement may investigate it.

Signature of **PATIENT/GUARDIAN:** _____ Date:_____ Time: _____

Signature of **SANE/WITNESS:** _____ Date:_____ Time: _____

******After the consent is completed contact LE to perform mandated reporting