UVA Health

0200002

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

AUTHORIZATION FOR FORENSIC SERVICES

I authorize_____RN, FNE and/or the Forensic Team to:

YES	NO	N/A	
☐	☐	☐	Perform a complete physical examination
☐	☐	☐	Perform a complete pelvic examination
☐	☐	☐	Collect appropriate evidentiary specimens
☐	☐	☐	Take photographs of my body for evidentiary and educational purposes
☐	☐	☐	Perform testing and give medications as applicable to my situation
☐	☐	☐	Notify, discuss and release evidence to the appropriate law enforcement officials

Patient Signature	Printed Name	Date	Time
Parent or Surrogate Decision Signature (if indicated)	Printed Name	Date	Time
FNE Signature	Printed Name	Date	Time
Witness Signature (if indicated)	Printed Name	Date	Time

INTERPRETER ATTESTATION (Use of Interpreter is required if patient/representative do not speak English)
Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID #	PRINTED NAME	DATE	TIME