STATE OF NEW YORK
DIVISION OF CRIMINAL JUSTICE SERVICES
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.

Name of person *receiving* the kit (print): ____

Signature: ____ Date/Time: ____________

ID#/Shield#/Star#/Title: ____________________ Precinct/Command/District: ____________

Person receiving kit is representative of: ____

Name of person *releasing* the kit (print): ____

Signature: ____ Date/Time: ____________

DO NOT PLACE THIS FORM INTO THE SEALED KIT

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