Authorization for Release of Information and Evidence to Law Enforcement

Patients Name:	
Date of Birth:	
Hospital Number:	

Attach Ferrington Tab Identification Here or Enter Patient's Name

I hereby authorize ____________________
(Name of Hospital)

to release the following information covering treatment given to me on ____________________
(month/day/year)

to ____________________
(Name of law enforcement agency)

	Authorized for Release	**Not Authorized for Release**
One sealed evidence kit, including specimens collected	☐	☐
X-rays or copies of X-rays taken in connection with examination	☐	☐
Photographs	☐	☐
Clothing	☐	☐
Other (specify):	☐	☐

Name of person authorizing release of information (please type or print): ____________________

Date: ____________________

Person authorizing release of Information is (check one): ☐ Patient ☐ Patient's Parents ☐ Patient's Guardian ☐ Other (specify): ____________________

Signature of person authorizing release of information: ____________________

Receipt of Information

I certify that I have received the following items (check those which apply):

☐ One sealed evidence kit ☐ X-rays or copies of X-rays ☐ Photographs
☐ Sealed clothing bag(s). If more than one sealed clothing bag, please note: ____________

Name of person receiving information and articles (print): ____________________

Signature of person receiving information and/or articles: ____________________ Date/Time: __________

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

Person receiving articles is a representative of: ____________________

Name of person releasing articles (print): ____________________

Signature of person releasing articles: ____________________

Distribute: One copy to patient
One copy to medical records
One copy to law enforcement agency

Revised last: May 2017