PAVSA SANE Office 218-726-1442
PAVSA 24-hour on call response: 218-726-1931
Serving Sexual Assault Victims at St. Mary's Medical Center & St. Luke's Hospital

Check indicates authorization

Reporting Options (Please Choose One)

Standard Report

☐ I am choosing to make a standard report to law enforcement. I give permission to the SANE Program to provide evidence collected and information documented during my sexual assault exam to law enforcement agencies involved in investigating this assault or prosecuting the assailant. This includes the release of my name and contact information.

☐ I authorize law enforcement agencies to release evidence regarding my case to the SANE program.

Anonymous 3rd Party Report

☐ I am choosing to anonymously report. I have read and understand the terms of anonymous reporting as outlined on the form "Anonymous 3rd Party Reporting Option."

Other

☐ (Please Explain): _____

Reporting Information (If applicable)

Law Enforcement Agency: _____ Incident Criminal Report Number: _____

Release to Physician (If applicable)

☐ I authorize the SANE Program to release all information obtained in my sexual assault exam and all other information relevant to my ongoing treatment to my primary care physician for continuing care purposes, upon request.

Physician: _____ Clinic: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is ____ (Date) or 1 year from today's date, whichever is sooner. **
- I understand that I may revoke this authorization at any time by notifying the SANE Program in writing. It will become effective on the date notified, but will not apply to any actions already taken.
- I understand I will receive a copy of this form after I have signed it.
- I understand a photocopy or fax of this form is the same as the original.

** *One year expiration of authorization does not apply to those choosing to anonymously report.*

Patient Signature Date

If I am signing as Authorized Representative of the patient, I am:

☐Parent of minor ☐Court appointed guardian/conservator

Print Name Signature of Authorized Person Relationship to Patient

AUTHORIZATION FOR RELEASE OF SEXUAL ASSAULT EXAM INFORMATION

PATIENT LABEL

Original to – SANE Program ***Copies to – Medical Records – Patient***

revised (9-21-2009)