Patient Label

CONSENT FOR MEDICAL-FORENSIC EXAMINATION

I consent and authorize _____ employed by _____ to
Medical Provider and Title **Name of Institution**
conduct a medical-forensic exam based on the components initialed below.

_____ I give consent for medical evaluation and treatment related to non-fatal strangulation. I understand I may withdraw my consent at any time for any portion of the exam.
Patient initials

_____ I give consent for evidence collection related to non-fatal strangulation. I understand I may withdraw my consent at any time for any portion of the exam.
Patient initials

_____ I give consent for photo-documentation related to non-fatal strangulation. I understand I may withdraw my consent at any time for any portion of the exam.
Patient initials

_____ _____
SIGNATURE OF PATIENT/PARENT/GUARDIAN IF PARENT/GUARDIAN, PRINT NAME & RELATIONSHIP

_____ _____
SIGNATURE OF MEDICAL PROVIDER PRINTED NAME OF MEDICAL PROVIDER

_____
DATE