SOVA

State of South Carolina State Office
of Victim Assistance
Medical Examination Release
☐ **No Evidence Collected (NKC)**

In the matter of:

_____   _____
Patient   Name of Health Care Provider

_____   _____
Address   Address

_____   _____
City   State   Zip   City   State   Zip

In accordance with South Carolina Victims and Witnesses Bill of Rights, signed into law on June 22, 1984, I hereby voluntarily consent and authorize the South Carolina State Office of Victim Assistance (SOVA) and its authorized agents to receive my medical records. I also authorize SOVA to pay such medical expenses allowed by law to Health Care Providers for routine medical tests and examinations for evidentiary purposes as prescribed by South Carolina Law Enforcement Division (SLED)/South Carolina Hospital Association.

Dated this _____ day of _____, 20_____, at

_____, South Carolina.

_____   _____
Signature of Patient/Guardian/Responsible Adult   Health Care Official's Signature (SANE/MD)

_____   _____
Print Name of Law Enforcement Officer   Signature of Law Enforcement Officer

Name of Law Enforcement Agency (Do not abbreviate)   For Anonymous Reporting: write in **"Anonymous"**

_____   _____
Incident Location   (County and State)   Date of Crime

The following questions MUST be answered:

Was the incident location in a federal, state, county or municipal jail, prison or other correctional facility?[1]   ☐ Yes ☐ No

Was the patient confined in a federal, state, county, or municipal jail, prison or other correctional facility at the time of service?[2]   ☐ Yes ☐ No

Was physical injury sustained?   Yes ☐   No ☐   Was medical treatment required?   ☐ Yes ☐ No

List injuries or physical complaint: _____

[1,2] If you answered <u>NO</u> to questions[1,2], attach a copy of SOVA Sexual Assault Protocol (SAP) Billing Statement to this Medical Examination Release Form for payment and forward to:

STATE OFFICE OF VICTIM ASSISTANCE
1205 Pendleton Street, Rm. 401
Columbia, South Carolina 29201
Phone: (803)734-1900