South Carolina Attorney General's Office
South Carolina Crime Victim Services Division
Department of Crime Victim Compensation (DCVC)

Sexual Assault Medical Examination Release Protocol Form

☐ **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 Department of Crime Victim Compensation (DCVC) and it's authorized agents to receive my medical records. *(relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me which could identifies my name, address, social security number, and account ID number).* This authorization is valid from the date of my/my representative's signature below and shall expire twelve month after the listed date. I also authorize DCVC 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 State 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

*** Required**

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 NO to questions[1,2], attach a copy of DCVC Sexual Assault Protocol (SAP) Billing Claim Form to this Medical Examination Release Form** for payment and forward to:

Department of Crime Victim Compensation (DCVC)
Edgar A. Brown Building, 1205 Pendleton Street, Room 401, Columbia, SC 29201
Telephone 803-734-1900 ● Facsimile 803-734-2261