DCH 1253 (10/04)

DEPARTMENT OF COMMUNITY HEALTH-PUBLIC HEALTH

VICTIM AUTHORIZATION REGARDING NOTIFICATION OF TEST RESULTS

(Authority, P.A. 368/1978, June 1994)

CASE NUMBER	DEFENDANT/JUVENILE'S NAME	DEFENDANT/JUVENILE'S DATE OF BIRTH

VICTIM ADVOCATE'S OFFICE NAME AND ADDRESS	COUNSELING AND TESTING AGENCY /PHYSICIAN NAME AND ADDRESS
TELEPHONE NUMBER	TELEPHONE NUMBER

NAME AND ADDRESS OF VICTIM OR VICTIMS REPRESENTATIVE	
COUNTY	TELEPHONE NUMBER

The victim is a
- ☐ minor
- ☐ developmentally disabled person
- ☐ state ward

TO BE COMPLETED, SIGNED, AND DATED BY THE VICTIM OR VICTIM REPRESENTATIVE

☐ I do ☐ I do not want to be notified of the above named defendant's/juvenile's test results

Complete the following information only if you want to be notified.

I ask to be notified of the defendant's/juvenile's test results by the:
- ☐ counseling and testing agency/private physician conducting the test.
- ☐ counselor of the Victim Advocate office who is certified by the Michigan Department of Community Health.

I understand that all information I have disclosed in this authorization is confidential. I further understand that this authorization will only be provided to the counseling and testing agency or physician if I have requested that they notify me of the defendant's/juvenile's test results. I will keep the Victim Advocate Office notified of any change in my address or telephone number.

DATE	SIGNATURE OF VICTIM OR REPRESENTATIVE

INSTRUCTIONS TO THE VICTIM ADVOCATE:

This authorization is to be provided to the counseling and testing agency or the private physician conducting the test **only if the victim has asked to be notified of the test results by the counseling and testing agency or the physician.** If the victim has requested the victim advocate notify him/her, only two copies of this authorization need to be completed.

Complete Part A of form DCH-1252 and forward to the counseling and testing agency or physician as ordered. Attach a copy of this authorization as appropriate.

DISTRIBUTION:

Original - Victim Advocate
1st Copy- Physician.Testing Agency (if requested)
2nd Copy- Victim or Representative

INSTRUCTIONS FOR COMPLETING VICTIM AUTHORIZATION REGARDING TEST RESULTS FORM

The Victim Advocate Office is required to complete this form in compliance with 1988 PA 471. This form authorizes the release of the defendant's/juvenile's test results to the victim or his/her representative.

Please provide the following information in the space provided:
1. Case number
2. Defendant's/Juvenile's name
3. Defendant's/Juvenile's date of birth
4. Name and address of victim advocate's office
5. Name, address, county, and telephone number of the counseling and testing agency or physician conducing the test
6. Name and address of the victim or his/her representative

Please indicate by marking the appropriate box if the victim is:
- a minor
- developmentally disabled
- a state ward

The victim or his/her representative may request the defendant's/juvenile's test results or waive this right by checking the appropriate box.

If "I do" is checked, the victim or his/her representative may select the method of notification in one of two ways:
1. directly by the counseling and testing agency/physician who administered the test; or
2. through a counselor of the victim advocate's office.

Regardless of the selection, the victim or his/her representative is required to date and sign this form to show they received and understood the information provided to them.

Copies of this document are to be distributed as indicated on the front of this form.