

**DCH-1253, VICTIM AUTHORIZATION REGARDING NOTIFICATION OF TEST RESULTS**  
**(Authority, P.A. 368/1978, June 1994)**  
Michigan Department of Health and Human Services (MDHHS)  
(New 7-23a)

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**SECTION 1 - INFORMATION**

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Case Number	Defendant/Juvenile's Name	Defendant/Juvenile's Date of Birth
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Victim Advocate's Office Name and Address	Testing Site Name and Address (Including County)
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Victim Advocate's Telephone Number	Testing Site Telephone Number
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**SECTION 2 - TO BE COMPLETED, SIGNED, AND DATED BY THE VICTIM OR VICTIM'S REPRESENTATIVE**

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Victim or Victim's Representative Name and Address	Victim or Victim's Representative Telephone Number
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The victim is a            ☐ minor            ☐ developmentally disabled person            ☐ state ward

☐ 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 local health department who is certified by the MDHHS.

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 notified of any change in my address or telephone number.

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Signature of Victim or Victim's Representative

Date

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**SECTION 3 – VICTIM ADVOCATE**

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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 local health department.**

Complete Section 1 of DCH-1252 and forward to the counseling and testing agency or physician as indicated above. Attach a copy of this authorization as appropriate.

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Distribution

☐ Original – Victim Advocate

☐ 1st Copy – Physician/Testing Agency (if requested)

☐ 2nd Copy – Victim or Victim's Representative

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## INSTRUCTIONS FOR COMPLETING DCH-1253, VICTIM AUTHORIZATION REGARDING TEST RESULTS

The Victim Advocate 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.

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 conducting the test.
6. Name and address of the victim or his/her representative

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 local health department.

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.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.