**Consent/Authorization for Forensic Interview**

Full Name of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have authority to consent to evaluation of the above-named minor child as:

\_\_\_\_\_ The child’s parent

\_\_\_\_\_ The child’s legal guardian or custodian

\_\_\_\_\_ DSS Director acting pursuant to a court order in accordance with N.C.G.S 7B-505.1(b)

I do hereby authorize Sampson County Child Advocacy Center to perform a forensic interview on the above named child. I acknowledge that the evaluation is used in making decisions regarding allegations of child physical abuse, sexual abuse, and/or neglect.

I understand this interview will be observed by other professionals working on this case. I also understand the interview will be recorded. This recording will be stored in a locked file at Sampson County Child Advocacy Center and will only be given to the investigating law enforcement agency. I understand I will not be allowed to observe the interview.

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Patient or legally authorized individual signature Date

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Relationship to the patient Signature of Witness