



# Office of Victim Services

**KATHY HOCHUL**  
Governor

**ELIZABETH CRONIN ESQ.**  
Director

## FRE Provider Email Attestation

I certify that the following individuals are authorized to receive and view confidential, patient-level health and billing information pertaining to forensic rape exam services rendered by medical personnel employed by, or contracted with, my program.

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Program Director/Manager Name

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Program Director/Manager Signature

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Program

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Date

Employee Name	Employee Title	Business Email Address

**Emailed or mailed scans, image files, or copies of this form are acceptable.  
Emailed copies should be sent to OVS.sm.FRE@ovs.ny.gov**