



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.

Program Director/Manager Name

Program Director/Manager Signature

Please list all providers your program represents.
List names ***exactly*** as shown on FRE claims forms. (Attach additional pages if necessary.)

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**