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| dhs_logo_oneline | | | | | | | | | | | | | | | | | | Voluntary Consent Form  LEDS Medical Database | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Purpose of this program:** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| ***By completing this form the signer is authorizing the release of protected health information to law enforcement agencies and other emergency responders.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | The information in this form will be entered into the Law Enforcement Data System to help responding agencies assist persons with a qualifying illness or condition in obtaining medical, mental health and social services when responding to a request for an emergency service. The information will be accessed only to provide necessary information to responding law enforcement officers and other emergency personnel to assist in an emergency situation. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Please check one:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | | Enrollment (first time) | | | | | | | | | | |  | | | Renewal/re-enrollment | | | | | | | | | | | | | | | |  | | | | Disenrollment/termination | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Name of individual to be entered into the database:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Last: | | |  | | | | | | | | | | | | | | | | |  | | First: | | | |  | | | | | |  | | Middle: | | | | | | | |  | | | | |  | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Date of birth: | | | | | /     / | | | | | | | | | | | | | |  | | Gender:  Male  Female | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Drivers license identification number: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | State: | | | | |  | | | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Drivers license expiration date: | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | |
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| **Description:** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Height: | | | |  | | | |  | Weight: | | | | | |  | | | | | | | |  | | | | Hair color: | | | |  | | | | | | | |  | | Eye color: | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Scars/marks/tattoos: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Illness/condition information: REQUIRED** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Provide symptoms, activities or other information that would be helpful for a responding officer to be aware of for the safety of this person and others. Please provide as much information as possible. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (If additional space is needed, please continue on a separate piece of paper. Indicate above that there are additional pages.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Diagnosis** (if known): | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Last known address of person listed above:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | |
| Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Apt./space # | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | City/state/ZIP code | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
| **Phone numbers:** | | | | | | -     - | | | | | | | | | | | | | | | | | | |  | | | -     - | | | | | | | | | |  | | -     - | | | | | | | | |
|  | | | | | | Home | | | | | | | | | | | | | | | | | | |  | | | Cell | | | | | | | | | |  | | Message | | | | | | | | |
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| **Contact information:** | | | | | | | Required to have a minimum of two (2) listed. This information will be provided to | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| emergency personnel if the above person is contacted and in need of assistance. Fill out as many as possible. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Emergency contact: | | | | | | | | | | Name: | | | | | | |  | | | | | | | | | | | | | | Phone: | | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | Relationship to person listed above: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| Case manager/clinician: | | | | | | | | | | Name: | | | | | | |  | | | | | | | | | | | | | | Phone: | | | | | |  | | | | | | | | | | | |
| Probation officer: | | | | | | | | | | Name: | | | | | | |  | | | | | | | | | | | | | | Phone: | | | | | |  | | | | | | | | | | | |
| Primary care physician: | | | | | | | | | | Name: | | | | | | |  | | | | | | | | | | | | | | Phone: | | | | | |  | | | | | | | | | | | |
| DCHS Mobile Crisis Team: | | | | | | | | | | Name: | | | | | | | DCHS Mobile Crisis Team | | | | | | | | | | | | | | Phone: | | | | | | 541-610-2376 | | | | | | | | | | | |

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| Voluntary Consent Form LEDS Medical Database *(continued)* | | | | | | | | | | | | | | | | | | | | | | |
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| **Please type or print clearly.** | | | | | | |  | | | | | | | | |  | | | | | | |
| Name of person submitting this form: | | | | | | | |  | | | | | | | |  | | | | | | |
| Address: | | |  | | | | | | | | | | | | |  | | | | | | |
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| **Witnessed by:** To be valid, the express written consent of this form must be witnessed by at least | | | | | | | | | | | | | | | | | | | | | | |
| two adults and at least one witness shall be a person ***who is*** ***not:*** | | | | | | | | | | | | | | | | | | | | | | |
|  | (A) A relative of the individual by blood, marriage or adoption or; | | | | | | | | | | | | | | | | | | | | | |
|  | (B) An owner, operator or employee of a health care facility in which the individual is a patient or a resident. | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | |
| The individual’s primary care physician or mental health services provider or any relative of the physician or provider, may NOT be a witness. Any employee of Deschutes County Health Services may NOT be a witness. | | | | | | | | | | | | | | | | | | | | | | |
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| **Witness number 1:** *(Print clearly or type.)* | | | | | | | | | | | | | | | |  | | | | | | |
| Name: | |  | | | | | | | | | | |  | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | |  | | |
| Phone number: | | | | | |  | | | | | | |  | | | | | | | | | |
| Relationship to person this form is being filed for: | | | | | | | | | | | | |  | | | | | | |  | | |
| Relationship to person submitting this form: | | | | | | | | | | | | |  | | | | | | |  | | |
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| Signature: | | | |  | | | | | | | | | | |  | Date: | | |  | | | |
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| **Witness number 2:** *(Print clearly or type.)* | | | | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | |  | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | |  | | |
| Phone number: | | | | | |  | | | | | | |  | | | | | | | | | |
| Relationship to person this form is being filed for: | | | | | | | | | | | | |  | | | | | | |  | | |
| Relationship to person submitting this form: | | | | | | | | | | | | |  | | | | | | |  | | |
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| Signature: | | | |  | | | | | | | | | | |  | Date: | | |  | | | |
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| A community mental health and developmental disabilities program director or designee shall enter an individual’s information into the medical health database no later than seven days after receiving a completed enrollment form and has: (1) verified that the individual has a qualifying illness or condition; and (2) obtained the express written consent of: (A) The individual; or (B) A person authorized to make medical decisions for the individual, if the individual is subject to a guardianship, an advanced directive for health care, a declaration for mental health treatment, or a power of attorney that authorizes the person to make medical decisions for the individual; or (C) A parent of the individual, if the individual is under 14 years of age. | | | | | | | | | | | | | | | | | | | | | | |
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| For DCHS Administrative use only: | | | | | | | | | | | | CPMS number: | | | | |  | | | | | |
| Date received: | | | | |  | | | |  | Date entered into database: | | | | | | | |  | | | | |
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This document can be provided upon request in alternative formats for individuals with disabilities. Other formats may include (but are not limited to) large print, Braille, audio recordings, Web-based communications and other electronic formats. E-mail [dhs.forms@state.or.us](mailto:dhs.forms@state.or.us), call 503-378-3486 (voice) or 503-378-3523 (TTY), or FAX 503-373-7690 to arrange for the alternative format that will work best for you.