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| dhs_logo_oneline | Voluntary Consent FormLEDS Medical Database |
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| **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: |       |  |  |
|  |  |  |
| **Description:** |  |  |
| Height: |       |  | Weight: |       |  | Hair color: |       |  | Eye color: |       |
|  |  |  |
| Scars/marks/tattoos: |       |
|  |
| **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): |        |
|  |
| **Last known address of person listed above:** |       |  |       |
|  Street | Apt./space # |
|  |       |  |
|  | City/state/ZIP code |  |
| **Phone numbers:**  |     -     -       |  |     -     -       |  |     -     -       |
|  | Home |  | Cell |  | Message |
|  |
| **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. |
|  |  |  |
| 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: |       |  |
| Phone number: |       | Relationship: |       |  |
|  |
| Signature: |  |  | Date: |       |
|  |
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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. |
|  |
| **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: |       |  |
|  |
| Signature: |  |  | Date: |       |
|  |
|  |
| **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: |       |  |
|  |
| Signature: |  |  | Date: |       |
|  |
| 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.  |
|  |
| 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, 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.