DHS
Oregon Department of Human Services

Volunteer 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 the 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 only be accessed to provide necessary information will only be accessed to provide necessary information to responding law enforcement officers and other responding emergency personnel to assist in an emergency situation.

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: ___/___/_____ Social Security number: ___-___-_____

Drivers license identification number: _____ State: _____ Gender: choose one

Drivers licenses expiration date: _____ CPMS number: _____

Description:

Height: _____ Weight: _____ Hair color: _____ Eye color: _____

Scars/marks/tattoos: _____

(Use proper codes when entering this into LEDS.)

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: ___-___-_____ Resident ___-___-_____ 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. Please fill out as many as possible.

Emergency contact: Relationship to person listed above: _____
Name: _____ Phone: _____

Case manager: Name: _____ Phone: _____

Probation officer: Name: _____ Phone: _____

Primary care physician: Name: _____ Phone: _____

Please type or print clearly.
Name of person submitting this form: _____
Address: _____
Phone number: _____ Relationship: _____
Signature: _____ Date: _____

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.

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: _____

Date received: _____ Date entered into database: _____

A community mental health and developmental disabilities program director 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; (B) A person authorized to make medical decisions for the individual, if the individual is subject to a guardianship, advanced directive for health care, declaration for mental health treatment of 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.

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.