Marion County
OREGON
Health Department

LEDS Medical Database Consent Form

Reset

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 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: ____-____-____

Street _____ Apt./space # _____

_____

City/state/ZIP code

Phone numbers: ____-____-____ ____-____-____ ____-____-____

Residence Cell Message

Drivers license identification number: _____ State: _____ Gender: Choose One

Drivers licenses expiration date: _____

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.)

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: _____

I can cancel this authorization of release at any time in writing to Marion County Health Department, in which case, the information I have volunteered will be retracted from LEDS. I understand that information about my case is confidential and protected by the state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

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: _____ _____

Staff Only

Date received: _____ Date entered into database: _____ MOTS: _____

Supervisor Reviewed by: _____ Date _____

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.