Volunteer Consent Form
Law Enforcement Medical Health Database (LEDS)

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: _____

Drivers license identification number:_____ State:_____ Gender: ☐ Male ☐ Female

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*

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:_____

LCHS Name:_____ Phone:_____

Probation officer: Name:_____ Phone:_____

Primary Care Physician: Name:_____ Phone:_____

I can cancel this authorization of release at any time in writing to Linn County Health Services, 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 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 relative of the individual by blood, marriage or adoption, or; 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 (7) days after receiving a completed enrollment form and has: (1) verified that the individual has a qualify 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.

Frequently Asked Questions

Oregon House Bill 3466 passed during the 2009 session and provides a means by which individuals with mental illness or developmental disability can *voluntarily* disclose their medical information to a Community Mental Health Program (CMHP) that will then be made accessible to law enforcement agencies during an emergency.

The intent of the legislation was to create a way 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.

This is an opportunity to voluntarily provide information you would like law enforcement personnel to have if they come in contact with you during a time of crisis/emergency.

1) What is LEDS?
   Law Enforcement Data System. This is a State of Oregon database used by all law enforcement agencies to share information. Oregon State Police are the gatekeepers of the information.

2) Who will have access to the information?
   All Oregon Law Enforcement agencies. These officers have had extensive training regarding the use and limits of the information put into LEDS.

3) What if my information changes?
   You can contact your therapist/case manager, or go to the Sheriff's Office, to request your information be updated.

4) How long will my information be in LEDS?
   Until you or your guardian requests it removed.

5) Can I change my mind?
   You can at any time have your information removed from LEDS. Information that has been shared, as with any release, cannot be retracted.

6) How will my information be used?
   Law Enforcement will use your information during legal contacts or crisis/emergency situations in an effort to best serve you. This may include contacting agencies that are providing services such as mental or physical health, or family members or friends. These contacts are chosen by you to be entered into LEDS. You decide what information is provided that best helps you.

7) Why now?
   HB 3466 was passed into law on January 01, 2010 making it a requirement "to create medical health database to aid law enforcement agencies in assisting persons with mental illness." This is to assist officers if they come in contact with persons with mental illness to understand who to contact in a crisis/emergency and to understand if such person may have special needs.