

OREGON DEPARTMENT OF CORRECTIONS
Operations Division
Health Services Section Policy and Procedure #P-H-02.1

SUBJECT: NOTIFICATION IN EMERGENCIES

POLICY: An inmate's family, legal guardian or personal representative will be notified in the event of serious illness, injury or death.

REFERENCE: NCCHC Standard P-H-02
NCCHC Standard MH-H-02
OAR 291-027-0050 (Death Inmate)
HIPAA 164.510 (b) (1) (i) (ii)
Officer of the Day Manual

PROCEDURE:

1. Information regarding inmates' next of kin, legal guardian or personal representative is obtained by the counselor during the intake process. The inmate's counselor is responsible for updating this information with the inmate annually. This information is kept in the inmate's central file and updated on the Corrections Information System.
2. The "Health Services Emergency Notification" form (see attachment 1) is made available to all inmates through the Admission and Orientation process upon admission to the Oregon Department of Corrections. The purpose of this form is to allow Health Services to speak to designated family, friends, significant others, etc. when they inquire about various health related issues. Examples of these issues may include, but are not limited to, surgeries, hospitalizations, infirmary admissions, on-site emergency care, off-site emergency care and chronic diseases.
3. An inmate's mental health section is confidential and cannot be released to family, friends, significant others, etc. unless the inmate has signed an "Authorization to Use and Disclose Health Information" form (see attachment 2). These requests will be forwarded to BHS for proper handling.
4. During annual tuberculosis screening, inmates will be offered new forms to fill out as needed.
5. These forms are filed under "Consents" in both the mental health and medical sections of the health care record.
6. In the event of a life threatening illness or injury, it is the responsibility of the health care staff to notify the Officer-in-Charge (OIC). The Officer-in-Charge is then responsible for the notification of the next of kin, legal guardian or personal representative.

Effective Date: _____

Review date: August 2015

Supersedes P&P dated: August 2014

**Oregon Department of Corrections
HEALTH SERVICES EMERGENCY NOTIFICATION**

I DO NOT WANT INFORMATION PROVIDED TO ANYONE

Signature

Date

I DO WANT INFORMATION PROVIDED - see below

Signature

Date

In the event of an inquiry into my health condition or care during my incarceration; or a medical emergency requiring lifesaving intervention and/or hospitalization, I hereby authorize the Oregon Department of Corrections, Health Services Section to release the following confidential medical information to those listed below:

- Serious illness, planned hospitalization or surgery
- Health emergency or death
- Inquiry regarding my health condition and/or care
- Mental health information limited to a general overview of services available

In the event of my death, I understand that the Oregon Department of Corrections will contact this person to make arrangements for the final disposition of my property and my remains in accordance with Division 27 Death (Inmate).

Names and addresses of those to receive information:

Primary Contact

Secondary Contact

Name

Name

Relationship

Relationship

Street address

Street address

City, State, Zip Code

City, State, Zip Code

Telephone Number

Telephone Number

My consent may be revoked or changed at any time. The only exception is when the action has already occurred as instructed in this consent. Unless revoked earlier, this consent will expire one year from the date of signing.

Signature

Date

Revised: 9/2014

Name: _____
SID #: _____
DOB: _____

RETURN THIS FORM TO HEALTH SERVICES UPON COMPLETION. THANK YOU. CD1684

Departamento de Correcciones de Oregon
NOTIFICACIÓN DE EMERGENCIA DEL SERVICIO DE SALUD

NO QUIERO DAR INFORMACIÓN A NADIE

Firma

Fecha

SI QUIERO DAR INFORMACIÓN A ALGUIEN – MIRE ABAJO

Firma

Fecha

En caso de una investigación acerca de mi condición física o cuidado durante mi encarcelamiento, o un emergencia medica que requerir, intervención para salvar la vida o hospitalización. Yo le doy autorización a la División de Servicios de salud del Departamento de Correcciones de Oregon, para que le den la información confidencial médica a esos nombrado aquí en seguida.

- _____ Enfermedad grave, hospitalización o cirugías
- _____ Emergencia de salud o muerte
- _____ Investigación con respeto de mi salud o cuidado
- _____ La información de salud mental limitada a una visión general de servicios disponibles

En caso de mi muerte, Yo entiendo que el Departamento de Correcciones de Oregon se pondrá en contacto con esta persona para hacer preparativos final de mi propiedad y mis restos de acuerdo con la División 27 Death (Inmate)

Nombres y domicilios de las personas que recibirán información:

Contacto Primario

Contacto Secundario

Nombre

Nombre

Relación

Relación

Número y Calle

Numero y Calle

Ciudad, Estado y área postal

Ciudad, Estado y área postal

Numero de teléfono

Número de teléfono

Mi consentimiento puede ser revocado en cualquier momento. La única excepción es cuando la acción ya haiga ocurrido como esta dictado en este consentimiento. A menos que no sea revocado antes, este consentimiento expirara un año desde la fecha firmada.

Firma

Fecha

Revisado: 9/2014

Nombre: _____
Número de Identificación: _____
Fecha de nacimiento: _____

FAVOR DE REGRESAR ESTA FORMA A HEALTH SERVICES AL COMPLETAR. GRACIAS.

CD1684

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize _____
(Name and address of facility/health care provider you wish to release information)

To release information requested for (either DOB or SID is REQUIRED to identify records).

(Name of inmate making request) D.O.B. _____ SID # _____
(Date of Birth) State Identification)

To: _____ For the purpose of _____

By INITIALING the spaces below, I specifically authorize the release of the following records, if such records exist:

- All hospital records (including nursing records and progress notes)
- Transcribed hospital reports Pathology reports Other (Explain below)
- Medical records needed for continuity of care Diagnostic imaging reports _____
- Most recent five year history Clinician Office Charts notes _____
- Laboratory reports Dental records
- Emergency and Urgency care records
- Please send the entire medical records (All information to the above named recipient)

I authorize the Information listed below to be used, disclosed, or received by placing my INITIALS next to the information:

- *HIV/AIDS – related records (Copies will not be released to inmates while incarcerated)
- *Genetic testing information
- *Mental Health-list specific info requested _____
- **Alcohol and Drug Information

****PROHIBITED RE-DISCLOSURE.** This information has been disclosed to you from records protected by federal Confidentiality Rules (42-CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42-CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

*Must be initialed to be included in other documents.

This authorization is limited to the following time period: _____

This authorization is limited to a worker’s compensation claim injuries of: _____

My signature indicates that I authorize the disclosure of the above information and understand the following:

I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits.

I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

I understand this change will not affect information that has already been share.

I understand that federal and state law protects my health information. However, my information could be shared with agencies or business that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.

(Signature of Patient)

(Date)

(Signature of legal/personal representative authorized by law)

(Date)