

**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).
4. The institution inmate newsletters will periodically print notices reminding inmates to inform health services staff when information on these forms need updated. In addition, 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: May 2009

Supersedes P&P dated: August 2008

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: 5/2009

Name: \_\_\_\_\_  
SID #: \_\_\_\_\_  
DOB: \_\_\_\_\_

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

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: 8/2009

Nombre: \_\_\_\_\_  
Número de Identificación: \_\_\_\_\_  
Fecha de nacimiento: \_\_\_\_\_

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

