AFFIDAVIT OF CONSENT FOR 3rd PARTY
STATE OF TEXAS
COUNTY OF ELLIS

I, _____, reside at _____, _____, Ellis County, Texas _____.

I am the Parent, Guardian, or Responsible Party for _____, M/F, DOB:_____.

____ I am the Parent of the above-named individual.
____ I am the Guardian of the above-named individual.
Please provide Notarized Power of Attorney.
____ I am the Responsible Party of the above-named individual.
Please provide Notarized Power of Attorney.

I hereby authorize the Midlothian Texas Police Department (MPD) to use the information on the Midlothian Police Department Crisis Intervention Unit Fact Sheet (04/02/2021) to assist responders in any Medical and/or Mental Health response the above-named individual may be associated with.

I understand that the information I provide will be safeguarded by the Midlothian Police Department, and only be provided to select members of the MPD Crisis Intervention Unit should the specific need arise. A "Specific Need" may be any police, fire, medical emergency, or unknown emergency that the named person may be associated with, in or out of Ellis County, Texas.

Further, I give my consent to the Midlothian Police Department to provide this information to other first responders in emergency situations the named person may be involved.

I understand that the information released is for the specific purpose stated above. Any other use of this information, without the written permission of myself, is prohibited. However, I understand that any disclosure of information carries with it the potential for an unauthorized re-discloser and the information may not be protected by federal confidentially rules.

I understand that I may revoke this authorization at any time by contacting the Midlothian Police Department in writing. I understand that the revocation will not apply to information already released in this response to this authorization.

Doctor/Medical Information

1. List Doctor or Medical Provider Name, Number, and address:

   _____

   _____

2. List any Doctor Diagnosed Mental Illness:

   _____

3. List Date **or** Approx. Date of Diagnosis by Doctor:

   _____

4. Medications Prescribed: _____

   _____

   _____

5. Taking Medications: ( )Yes ( ) No
6. Illegal Drugs: ( )Yes ( )No _____
7. Alcohol Use: ( )Yes ( )No / If so how often:_____
8. List any triggers that might cause duress: _____
9. Will you submit a current photo for our records so that our officers can quickly identify the individual under your care? ( ) Yes ( ) No
10. Emergency Contact Person:_____Relationship:_____
11. Emergency Contact Number:_____

I acknowledge that I have read this authorization and fully understand its contents.

Signed: _____

Date: _____

Unless otherwise revoked, this authorization shall expire one year from the date signed.

Witness Signature:_____

Witness Printed Name:_____

Date:_____