#### **Restore House**

Residential Treatment Program Application PO Box 1191, Bemidji, MN 56619 218-444-9420 (phone) 218-444-9212 (fax)

#### Mary Greer, Program/Treatment Director 218-760-4209 (phone)

Date\_\_\_\_\_

Personal Informa	ation:						
Full Name:							
Address:	(First)	•	ddle)	(Last)			
Address:(S			(City) ocial Security Numb		(Zip Code) -		
			cedSeparated				
Phone #	_		·				
Emergency Conta	act Person:	(Name)	Relationship:(Name)				
(Street Address)	(City)		(Zip Code)	(Phone Nu	mber)		
2 <sup>nd</sup> Emergency C	2 <sup>nd</sup> Emergency Contact Person:Relationship:						
(Street Address)	(City)	(State)	(Zip Code)	(Phone Nu	mber)		
Rule 25 Assessor	::						
	(Name) (Phone Number)						
Date of last Rule	25/Chemica	al Dependenc	y Assessment:				
Corrections Age	e <b>nt</b> (if applicat	ole):					
(Name)	(Name) (Phone)						
Attorney/Public	Defender Inf	ormation (if ap	plicable):				
(Name)			(Phone	e)			
Next Court Date (if applicable):							
Have you ever b		ed as a sex off	ender in Minneso	ta or any other	state?		
If yes please Exp	olain:						

Date last used alcohol/illicit drugs:				
Write a brief biography of your life, including your spiritual experiences:				
Why are you interested in being a part of a Residential Treatment Program?				
Who has encouraged you to become a part of Restore House?				
who has encodinged you to become a part of kestore house:				
<u>Dismissal</u> :				
I understand that any violation of Restore House program rules could result in my immedia discharge and eviction from the program/home. No financial refund will be given.	ıte			
I authorize Restore House staff to contact any individuals named in this application. Also, I				
authorize Restore House staff to exchange information with board and committee members				
regarding application and acceptance.				
Signature Date				
Signature				
Submitted to the committee: (Date)  Committee decision:				

# RESTORE HOUSE INC. Residential Treatment Facility CONSENT FOR RELEASE OF INFORMATION

51756 229<sup>th</sup> Avenue Bemidji, Minnesota 56601 Phone: 218-444-9420 P.O. Box 1191 Bemidji, MN 56619-1191 Fax: 218-444-9212 1001 Mississippi Ave. NW Bemidji, MN 56601 Phone: 218-444-9102

Name: (Last)		(First)		(M.l.)
	Phone: (	)	Date	e of Birth:
I hereby do give consent and a	authorize: Restore H	ouse Inc		
X To release information X Obtain information fro				
• •				
Address:				
Phone:				
Information can be communicated the purpose of this		ılly, <u>X</u> Wri	tten, and/or	X_Facsimile.
I understand the purpose of this				
accessed the Res	tore House Inc. for	treatment servi	ces.	regarding the client who has
X other purposes, pl	ease specify:			
I understand the specific inform  X Discharge Summary  X Chemical Depender  X Progress in Treatmen  X Acknowledgement of  X History and Physical  X Doctor's consult resu	ncy Evaluation t/Progress Notes of Client's access o		XAssessment XTreatment F XLab: Urine [ XPsychologic XCommunic	/Admission Intake Plan/Recommendations Drug Screens cal/Psychiatric Consults
Effective this date			taken, can be revol	_unless revoked by me. ked at any time.
I understand that information otherwise provided for in lega conditions of this release and the SIGNATURE:	statutes and judio	cial orders. My	signature below in	dicates that I understand the
NOTICE: Further disclosure of co	onfidential informa	tion without the	e specific written co	onsent of the person to whom
it pertains is prohibited by state				
disclosed to you from records you from making any further di consent of the person to whon the release of medical or othe the information to criminally inv	orotected by Fede sclosure of this info n it pertains or as o r information is NO	ral Confidentia rmation unless therwise permi T sufficient for t	lity Rules 42 CFR Pa further disclosure is tted by 42 CFR Part his purpose. The Fe	rt 2. The Federal Rules prohibit expressly permitted by written 2. A general authorization for deral Rules restrict any use of
I revoke this authorization for F persons.	Release of Informat	tion on	20for the	above designated person or

Signature\_\_\_\_\_ Witness Initials\_\_\_\_\_

#### FOR YOUR PUBLIC DEFENDER/ATTORNEY

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Name: (Last)	(First)		(M.I.)	
Phone: (	)	Date	of Birth:	
I hereby do give consent and authorize: Restore	HouseInc			
X To release information to:				
X Obtain information from:				
Company/Individual Name: Public defe	ender			
Address:				
City: <u>Bemidji</u>		State: MN	Zip: <b>56601</b>	
Phone:		Fax:		
Information can be communicated: XVerl	oally, <b>X</b> Wr	itten, and/or	<b>X_</b> Facsimile.	
I understand the purpose of this release is to:				
X facilitate the assessment, treatmen accessed the Restore House Inc. for			egarding the client who has	
X other purposes, please specify:				
I understand the specific information to be discled Discharge Summary Chemical Dependency Evaluation Progress in Treatment/Progress Notes Acknowledgement of Client's access History and Physical Doctor's consult results		Assessment/ XTreatment PI XLab: Urine DPsychologic XCommunica	Admission Intake lan/Recommendations rug Screens al/Psychiatric Consults	
Effective this date NOTE: This authorization, except fo				
I understand that information in confidential records cannot be released without my written consent unless otherwise provided for in legal statutes and judicial orders. My signature below indicates that I understand the conditions of this release and that I give my authorization voluntarily.  SIGNATURE:  DATE:				
NOTICE: Further disclosure of confidential inform it pertains is prohibited by state and federal statu		e specific written co	nsent of the person to whom	
<b>NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS:</b> 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 unless further disclosure is expressly permitted by 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. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.				
I revoke this authorization for Release of Inform persons.	ation on	20for the a	above designated person or	
Signature	<u> </u>		Witness Initials	

#### FOR YOUR RULE 25 ASSESSOR

# RESTORE HOUSE INC. Residential Treatment Facility CONSENT FOR RELEASE OF INFORMATION

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\_\_\_\_\_ Witness Initials\_\_\_\_

Name: (Last)		(First)		(M.I.)
	Phone: (	)	Date	of Birth:
I hereby do give consent and a	authorize: Restore F	louseInc		
X To release information X Obtain information fro Company/Individual N	m:	essor		
			City (	State:
			•	state:
Phone:				
Information can be communicated	ated: XVerba	ally, X <u> </u>	and/or	XFacsimile.
I understand the purpose of this	s release is to:			
accessed the Res	tore House Inc. for	treatment services.		egarding the client who has
I understand the specific inform Discharge Summary X Chemical Depender Progress in Treatmen Acknowledgement of History and Physical Doctor's consult resu	ncy Evaluation t/Progress Notes of Client's access o	) ) of service	<pre>Assessment/ Assessment Pi Lab: Urine D Psychologic Communica</pre>	Admission Intake lan/Recommendations rug Screens al/Psychiatric Consults
Effective this date				
NOTE: This author	zation, except for	action already take	n, can be revok	ed at any time.
I understand that information otherwise provided for in lega conditions of this release and the	I statutes and judio	cial orders. My sign		
SIGNATURE:			DATE:	
<b>NOTICE:</b> Further disclosure of continuous it pertains is prohibited by state		·	ecific written co	nsent of the person to whom
NOTICE TO WHOMEVER DISCLE disclosed to you from records p you from making any further di consent of the person to whon the release of medical or othe the information to criminally inv	orotected by Fede sclosure of this info n it pertains or as c r information is NC	eral Confidentiality Formation unless furth otherwise permitted OT sufficient for this p	Rules 42 CFR Part ner disclosure is e by 42 CFR Part : purpose. The Fec	t 2. The Federal Rules prohibit expressly permitted by written 2. A general authorization for deral Rules restrict any use of
I revoke this authorization for F persons.	Release of Informa	tion on	_20for the a	above designated person or

Signature\_\_\_

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Name: (Last)	(First)		(M.I.)
Phone: (_	)	Date	of Birth:
I hereby do give consent and authorize: Res	tore HouseInc		
To release information to:			
Obtain information from:			
Company/Individual Name:			
Address:	City:	State <u>:</u>	Zip:
Phone:		Fax:	
Information can be communicated:	Verbally,Writte	en, and/or	Facsimile.
I understand the purpose of this release is to	:		
facilitate the assessment, treati accessed the Restore House In			egarding the client who has
other purposes, please specify:			
I understand the specific information to be of Discharge Summary Chemical Dependency Evaluatio Progress in Treatment/Progress No Acknowledgement of Client's accomplication in the progress of the pr	n tes	Assessment/Treatment PlLab: Urine DiPsychologicaCommunica	Admission Intake an/Recommendations rug Screens al/Psychiatric Consults
Effective this date	to expire	kon can bo rovok	_unless revoked by me.
NOTE. This authorization, excep		en, can be revoke	
I understand that information in confident otherwise provided for in legal statutes and conditions of this release and that I give my	d judicial orders. My sig	gnature below ind	
SIGNATURE:		DATE:	
NOTICE: Further disclosure of confidential in it pertains is prohibited by state and federal		pecific written co	nsent of the person to whom
NOTICE TO WHOMEVER DISCLOSURE IS MA disclosed to you from records protected by you from making any further disclosure of th consent of the person to whom it pertains of the release of medical or other information the information to criminally investigate or pro-	Federal Confidentiality his information unless ful or as otherwise permitte is NOT sufficient for this	r Rules 42 CFR Part ther disclosure is e ed by 42 CFR Part 2 s purpose. The Fec	2. The Federal Rules prohibit expressly permitted by written 2. A general authorization for deral Rules restrict any use of
I revoke this authorization for Release of Integersons.	formation on	20for the a	bove designated person or
Signa	iture		Witness Initials