

#### **Red Lake Chemical Health Programs**

#### **PO Box 114**

#### Red Lake, MN 56671

Phone: (218) 679-3321 Fax: (218) 679-2727

#### **Assessment Request Form**

Date of Request:	DOB:		
Full Name:Last	First		M.I
Address:PO Box		ate	Zip Code
Address:Physical			
Home Phone:	Cell Ph	one:	
Work Phone:	Messag	je Phone:	
Social Security #:	Are You	ı Employed:	(Yes) (NO)
House Hold Size:	Annual	Income:	
Are you an IV user: (YES) (NO)			8
What is your method of use?:			
Please select one: (Voluntary)	(Court Ordered)	(Involun	tary Commitment)
	Office Use		
PMI #:	(PMAP) (Prim	eWest) (E	Blue Plus)
Other Insurance:	Proce	ntive Numbe	er:

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RED LAKE BAND OF CHIPPEWA INDIANS RED LAKE CHEMICAL HEALTH PROGRAMS RED LAKE, MINNESOTA 56671 (218) 679-3392

#### As a client you have these rights:

- 1. Every client shall have the right to considerate and respectful care.
- 2. Every client can reasonably expect to obtain from his/her counselor of the facility complete and current information concerning his diagnosis, treatment and prognosis in terms and a language the client can reasonably be expected to understand. In cases in which it is not medically advisable to give the information to the client. The information may be available to the appropriate person in his/her behalf.
- 3. Every client shall have the right to know by name and specialty, if any, the counselor responsible for coordination of his/her care.
- 4. Every client shall have the right to every consideration of his/her privacy and individually as it related to his /her social, religious, and psychological wellbeing.
- Every client has a right to respectfulness and privacy as it relates to his/her treatment program.
   Case discussions, consultation, examination, and treatment are confidential and should be conducted discreetly.
- 6. Every client shall have the right to obtain information as to any relationship of the facility to other health care and related institutions; in so far his/her care is concerned.
- 7. Every client shall have the right to expect reasonable continuity of care that shall include but not be limited to what appointment time counselors are available.
- 8. Every client shall be fully informed prior to or at the time of admission to the program, what services are available in the facility and so related changes including any charges for services not covered under Medicare, Medicaid or not covered under the facilities basic rate.
- 9. Every client should be afforded the opportunity to participate in the planning of his/her treatment and refuse to participate in experimental research.
- 10. No client shall be arbitrarily transferred or discharged but may be transferred or discharged only for therapy reasons, for his/her or to her clients welfare, or for nonpayment for stay unless prohibited by the welfare program paying for the care of the client as documented in the case file. Reasonable advance notice of any transfer or discharge must be given to a client prior to transfer or discharge.
- 11. Every client may manage his/her personal financial affairs, or shall be given at least a quarterly accounting of financial transactions on his/her behalf if he/she delegated this responsibility in accordance with the laws of Minnesota to the facility for any period of time.

(TURN PAGE OVER)

- 12. Every client shall be encouraged and assisted throughout his/her period in the program to understand and exercise his/her rights as a client and a citizen to this and, he/she may voice grievances and recommend changes in policies and services to facility staff and outside representative of his/her choice, free from restraint, interference, coercion, discrimination or reprisal.
- 13. Every client should be free from mental and physical abuse, free from chemical and physical restraints except in emergencies, or as authorized in writing by his/her physician for a specified and limited period of time and only when necessary to protect the resident from injury to himself/ herself or others.
- 14. Every client should be assured confidential treatment of his/her personal and medical records and may approve or refuse their release to any individual outside facility except as otherwise provided by law or third party payment.
- 15. No client shall be required to perform services for the facility that are not included for therapeutic purposes in his/her plan of care.
- 16. Every client may associate and communicate privately with persons of his/her choice.
- 17. Every client may meet with representative in activities of commercial, religions, and community groups at his/her discretions provided however that the activities shall not infringe up the right of privacy of other clients.
- 18. Every client shall be fully informed prior to or at the time of admission and during his/her stay in the program of the rights and responsibilities set forth in this section and of all rules governing client conduct and responsibilities.

Minnesota Statues 1974, Section 144,651 as amended; Complaints and/or grievances related to right expressed in the Patient's Bill of Rights or to any other patient rights may be resolved within this facility to be contracting.

*Client Signature	X *Date	
Red Lake Chemical Health Program Staff	 Date	

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### CLIENT TRANSPORTATION POLICY

Client attending outside treatment facilities will only be transported by Red Lake Chemical Health Programs to and from the facility, at the successful completion of treatment. After being transported to outside treatment the client must follow that facility's transportation policy.

Clients who leave a treatment facility on their own, or who are asked to leave, must find their own transportation home. Red Lake Chemical Health Programs will not transport clients who have not completed treatment. Parents, guardians, or referring agencies, i.e., Social Services, will be responsible for juveniles.

I have read and agree with the Red Lake Chemical Health Programs transportation policy.

Χ	✓
*CLIENT'S SIGNATURE	*DATE

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### MANDATED REPORTER POLICY

The Red Lake Chemical Health Programs Rule 25 Assessors are Mandated Reporters, which means they are obligated by Tribal and Federal guidelines to report the following:

- 1. Sexual, Physical and Emotional abuse, and neglect.
- 2. If you threaten to harm others, and
- 3. In certain circumstances, If you are in danger of harming yourself.

I have discussed, read, and agree with the Red Lake Chemical Health Program's Mandated Reporter Policy.

*CLIENT'S SIGNATURE	X- *DATE
PARENT/GUARDIAN SIGNATURE	DATE
RULE 25 ASSESSOR SIGNATURE	DATE

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### CLIENT'S RIGHT TO APPEAL

A CLIENT HAS THE RIGHT TO A FAIR HEARING UNDER MINNESOTA STATUES, SECTION 256.045, IF THE CLIENT:

- A. Is denied an assessment under part 9430.6615
- B. Is denies a second assessment under subpart 1;
- C. Is denied placement;
- D. Disagrees before services begin with the level of chemical dependency care of the length of placement that the tribe, county or prepaid health plan proposes to authorize;
- E. Is receiving authorized services and is denied additional services that would extend the length of the current placement beyond the end date specified in the placement authorization.
- F. Is denied a placement that is appropriate to client's race, color, creed, disability, national origin, religious preference, marital status, sexual orientation, or sex, or
- G. Objects under part 9530.6622, subpart 11 to a religious placement and is not given an alternate

For more services during the appeal of additional services and consideration in granting, or denying additional services, please refer to 9530.665 subparts 3 and 4. For clients who wish to use it, a form to request Appeal, approved by the Commission of Human Services, is available from the Assessment

A CLIENT assessed under Part 9530.6615 who disagrees with the treatment planning decision HAS A RIGHT TO A SECOND ASSESSMENT IF:

- A. The second assessment is requested within five days of the time the results of the first assessment are communicated to the client.
- B. The second assessment is requested in writing, and
- C. The client has not begun to receive services under the first assessment, prior to completing the

The program has five days after receipt of a valid, written request for a second assessment to make that second assessment available. If the client agrees with the outcome of the second assessment, the placing authority shall place the client in accordance with (part 9530.6622 and) the second assessment. If the client disagrees, the placing authority must place the client according to the assessment that is most consistent with the client's collateral information.

AS A CLIENT OF THE RED LAKE CHEMICAL HEALTH PROGRAMS, I HAVE READ AND I FULLY UNDERSTAND

X*CLIENT'S SIGNATURE	X
RED LAKE CHEMICAL HEALTH STAFF	DATE

### CONSENT FOR FOLLOW UP

Red Lake Chemical Health Programs is participating in the Minnesota Continuum of Care Pilot. The purpose of this project is to facilitate the flow of services as needed. The project gives us the resources to do some things we have not previously done.

We would also like your confidential feedback on how we are doing.

I agree to participate in the pilot. I agree to participate in a confidential Client Satisfaction survey.

V	
^*Initials or	Signature
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If you do participate in treatment, one thing we would like to do is have follow up contact with you after you finish treatment to continue to keep you in touch with resources as you need them. by authorizing this we can provide peer support or assistance accessing resources when you want, even when you are no longer in treatment.

I agree to provide Red Lake Chemical Health Programs with the best possible contact information for me and to update that information before I leave treatment. If there is any specific manner to best contact me, I agree to inform Red Lake Chemical Health Programs, care coordinators, or peer support staff or volunteers to use this information to contact me after I leave treatment to discuss how I am doing and will be more frequent immediately after treatment and will decrease with the passing of time, unless I request more frequent calls.

I understand that I can also call Red Lake Chemical Health Programs after my treatment completion.

*Typed or Printed Name	
X-*SIGNATURE	X-VATE

This permission expires two years after the signature date.

I understand that I can revoke this consent at any time, except to the extent that aftercare is included in my Court ordered Recommendation and I have agreed to this order to comply with my Court Order.

## Acknowledgement of receipt of Chemical Health Programs

### Notice of Privacy – Practices

I hereby acknowledge receipt of the Chemical Health Programs (CHP) Notice of Privacy Practices at:

#### CHEMICAL HEALTH PROGRAMS RED LAKE, MN 56671

X*SIGNATURE OF CLIENT	
SIGNATURE OF CLIENT	*DATE
SIGNATURE OF CLIENT REPRESENTATIVE State Relationship to client or witness (IF signature is by thumb print or mark)	DATE
SIGNATURE AND TITLE OF CHP EMPLOYEE	
For Clients unable to Acknowled I hereby certify that the client was unable to acknowledge received because:	dge receint
	and any mactice
Signature of CHP STAFF	DATE
Questions: Contact HIPAA Coordinator at (218) 679-3995	DATE

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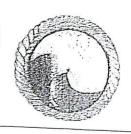
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	10, DATE OF SIGNATUR		ED COUNTY/TRISAL SIG		12. SOCIAL SEC	URITY #		13. LANGUAGE			14. HISPANIC? Y = Yes	TO A STANDARD ON SHALL THE
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	%	DRESS (ADDRESS, CITY, STAT) Y RESPONSIBLE PERSON (LA		2	22. FINA	NCIALLY RESPI	ONSIRE SESSONS ADDRESS		20. R	= White 4 = Armo	rican Indian 8 :	= Cihar = Unknown
		ESSMENT DATE 24, ASS INITIAL BOX IF CLIENT IS A N ES NOTIFICATION LETTERS BI CIALLY RESPONSIBLE PERSO		28. PLACEMEN	V IT EXCEPTION O.4	VI = Civil Commi	25. LIMITED EUG  25. LIMITED EUG  M = Minor  F = Pregnani  meni  99 = None	IBILITY  A = Ad  C = OI	lult with Micar	2ó.	SEHOLD SIZE	THE PROPERTY OF THE PROPERTY O
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2		SSATACNOMY/GONTRAGE:	D (ifnecessary)				SO. RESERVE FUND ELIGIBIE		125	COUNTY PAT 100%		SECOND STREET
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Private		OMPANY NAME AND ADDRI NO ADDRESS (if not the dier					48. CERTIFICATE/POUC		49. GROUP NA	ME #	50. PRE-CERTIFICA	TION #
I certify	that to the best of	my knowledge and	d belief, the infi	osmatia -			52, EMPLOYER OR POLI			1	53. RELATIONSHIP TO	
advance	of my revocation.	my knowledge and onsible for the total ical dependency se date services were If I revoke this aut rdian if Client is a minor	rendered. I un horization, I m	ent provid rize paym derstand t ay be resp	provided abouted. I authorizent of any thing the second of	ve is com se access rd party voke this ne total co	plete and correct to medical inform benefits directly to authorization at a ost of treatment.	. Lunderstar nation needs the Depart any time exc	nd that if the ed to determ ment of Hu apt to the a	e informatio mine health Iman Service Extent that ac	n provided is fi care and/or M es. This authori tions have take	alse or Nedicare zation en in
Financia	lly Responsible Pe for Policyholder if not the	C!							Date: _	Х		
		Graan Copy . C	ounty, Tribe or	Manage	d Care Orga	inization	-2°%	White	Copy - Cl	ient	N.	- North Annual Control
								A CONTRACTOR OF THE PARTY OF TH	CALL SECTION	30 30 TO		5

PO Box 114 Red Lake, MN 56671

Phone: (218) 679-3321

FAX: (218) 679-2727



#### RULE 25 CHEMICAL USE ASSESSMENT RESULTS AND RECOMMENDATIONS

Date: X	<u> </u>
To:	FROM: <u>RED LAKE CHEMICAL HEALTH</u>
	BOX 114
ė.	11:00071
This is to verify that	completed a Rule 25 Chemical
gathered from	collateral contacts.
According to Minnesota's Rule 25 Assess	nont Cuideline I a
	nent Guidelines, I find that
Dimension 1 CURRENT INTOXIO	CATION OR WITHDRAWAL
Dimension 2 PHYSICAL HEALTH	
Dimension 3 MENTAL, EMOTIO	NAL, OR BEHAVIORAL
Dimension 4 TREATMENT ACCE Dimension 5 RELASPE POTENTI	PTANCE
Dimension 6 RECOVERY ENVIRO	AL
and meets DSM IV TR criteria for	NIMENI
	Substance Use Disorder
My treatment recommendations are:	
NO TREATMENT NEEDED DWI CLINIC	
TREATMENT AT:	
suggested initial period of	for a
BOARD & LODGING AT:	
suggested initial period of	for a
OTHER RECOMMENDATION	E PROGRAM AT:
This client is is not financially elig	gible for the State Consolidate Fund to pay for their
	sort of the state consolidate rund to pay for their
Comments:	
L CORRECTOR	
ASSESSOR:	CLIENT: X
PARENT'S SIGNATURE(IF UNDER 16	5)

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# AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>COLLATERAL<<

			_	
1				
.,	X *(Client's Nam	16)	REQUEST 1	HAT THE RED LAKE
CHEN inform	MICAL HEALTH PROGRAM nation about my chemical us	AS RELEASE: partile and functioning in (TYPE OF INFORMATI	cipation in Rule 2 all life areas ON/DOCUMENT)	25 Assessment and receiv
TO and	d FROM		.,,	
	#/COLLATE	ide a history		
	COLLATER	RAL CONTACT'S NAI	ME & PHONE NUM	ÄREP)
FOR TH	HE PURPOSE OF			
	HE PURPOSE OF: collateral	contact (obtaining the CREASON OR PUR	nis person's perspe RPOSE)	ctive on my use)
A willful \$10,000 (U.S. Cod	ly false statement or repre D, or minimum imprisonmen de, title 18, section 1001, fo	esentation is a crimi t of 5 years, or both. ormerly section 80)	inal offense punis	hable by maximum fine of
X				
-	*SIGNATION OF	50 HOMES C		
	*SIGNATURE OF APPLIC IF OTHER THAN P	ANT (Patient, next of	kin, administration	of setate at a
	IN OTHER THAN PA	ATIENT INDICATED REL	ATIONSHIP OR ALITH	ARITY
				orari.
*CONTAC	T DUNNE OD ADDESE			•
ייייייייייייייייייייייייייייייייייייייי	CT PHONE OR ADDRESS (	OF APPLICANT		X *BATE
				A PURIE

This consent is subject to revocation at any time except to the extent that Chemical Health Programs has already taken action in reliance on it. However, if this consent was granted to show satisfaction of a legal or court order, then this permission cannot be revoked until that order has been satisfied.

#### TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

NOTE: Public Health Service Act 42. U.S.C Section 290dd-2, previously recognized as 42 C.F.R, Part 2, protects the confidentiality of all individual, client data. Any disclosure of information, which is not offense and not more than \$5,000 in the case of a first

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Red Lake, MN 56671

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# AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >> COLLATERAL <<

1	
X *(Client's Name)	REQUEST THAT THE RED LAKE
CHEMICAL HEALTH PROGRAMS RELEAS information about my chemical use and function (TYPE OF IN)	SE: participation in Rule 25 Assessment and receive ioning in all life areas
TO and FROM	
*(COLLATERAL CONTAC	ct's name & Phone Muniber)
FOR THE PURPOSE OF: collateral contact (obt (REASO)	taining this person's perspective on my use) N OR PURPOSE)
A willfully false statement or representation is \$10,000, or minimum imprisonment of 5 years, (U.S. Code, title 18, section 1001, formerly section	s a criminal offense punishable by maximum fine of on 80)
,	
*SIGNATURE OF APPLICANT (Pations	
IF OTHER THAN PATIENT INDICA	t, next of kin, administration of estate, etc.) ATED RELATIONSHIP OR AUTHORITY.
*Contact phone or address of applical	W GARRON
	V *Pate
has already taken action in reliance on it. Howeve	except to the extent that Chemical Health Brown

has already taken action in reliance on it. However, if this consent was granted to show satisfaction of a legal or court order, then this permission cannot be revoked until that order has been satisfied.

TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

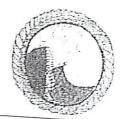
NOTE: Public Health Service Act 42. U.S.C Section 290dd-2, previously recognized as 42 C.F.R, Part 2, protects the confidentiality of all individual, client data. Any disclosure of information, which is not offense and not more than \$5,000 in the case of a first case of each subsequent offense.

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# AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>COLLATERAL<

X *(Client's Name)	REQUEST THAT THE RED LAKE
CHEMICAL HEALTH PROGRAMS RELEASE information about my chemical use and function (TYPE OF INF.)	E: participation in Rule 25 Assessment and receive oning in all life areas ORMATION/DOCUMENT)
TO and FROM	
*(COLLATERAL CONTAC	TEA 18 - 20 - 1
(SOLD BLIME CONTAC	T'S NAME & PHONE NUMBER)
FOR THE PURPOSE OF: collateral contact (obta (REASON	aining this person's perspective on my use) I OR PURPOSE)
A willfully false statement or representation is \$10,000, or minimum imprisonment of 5 years, of (U.S. Code, title 18, section 1001, formerly section	a criminal offense punishable by maximum fine of on 80)
*SIGNATURE OF APPLICANT (Patient, IF OTHER THAN PATIENT INDICA	, next of kin, administration of estate, etc.) TED RELATIONSHIP OR AUTHORITY.
*Contact phone or address of applican	V 5 = 2.5
his consent in auti	X *DATE

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TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

NOTE: Public Health Service Act 42. U.S.C Section 290dd-2, previously recognized as 42 C.F.R, Part 2, protects the confidentiality of all individual, client data. Any disclosure of information, which is not offense and not more than \$5,000 in the case of each subsequent offense.

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# AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>GENERIC<<

X' *(Offent's Name) REQUEST THAT THE RED LAKE
CHEMICAL HEALTH PROGRAMS RELEASE:
(TYPE OF INFORMATION/DOCUMENT)
TO
*(AGENCY OR INDIVIDUAL'S NAME & PHONE NUMBER)
FOR THE PURPOSE OF:
(REASON OR PURPOSE) \$10,000, or minimum imprisonment of 5 years, or both. (U.S. Code, title 18, section 1001, formerly section 80)
X
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)  IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.
*CONTACT PHONE OR ADDRESS OF APPLICANT
This consent is subject to revocation at any time and

This consent is subject to revocation at any time except to the extent that Chemical Health Programs has already taken action in reliance on it. However, if this consent was granted to show satisfaction of a legal or court order, then this permission cannot be revoked until that order has been satisfied.

#### TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

NOTE: Public Health Service Act 42. U.S.C Section 290dd-2, previously recognized as 42 C.F.R, Part 2, protects the confidentiality of all individual, client data. Any disclosure of information, which is not offense and not more than \$5,000 in the case of each subsequent offense. Violations can be reported to the United States Attorney for the District of Minnesota, 300 South 4th street, Number 600, Fisher's Lane, Rockville, MD 20857 or 1-800-SAMSHA-7 (877-726-4727 or TTY 1-800-487-4899).

## CHENICAL BEALLE PROGRAMS

PO Box 114 Red Lake, MN 56671

Phone: (218) 679-3321

FAX: (218) 679-2727



# AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >> GENERIC <<

1	X *(Client's Name)	REQUEST THAT THE RED LAKE
CHEMICAL HE	ALTH PROGRAMS RELEASE:	
	(TYPE OF INFOR	MATION/DOCUMENT)
TO		THOM DOCUMENT)
	*(AGENCY OR INDIVIDUAL'S	NAME & PHONE NUMBER)
FOR THE PURP	OSE OF:	
A willfully false s		criminal offense punishable by maximum
ADI&*	ATURE OF APPLICANT (Patient, ne IF OTHER THAN PATIENT INDICATED	ext of kin, administration of estate, etc.)  RELATIONSHIP OR AUTHORITY.
*CONTACT PHON	ie or address of applicant	X *DATE
This consent is sul	plect to revocation =:	C Street

This consent is subject to revocation at any time except to the extent that Chemical Health Programs has already taken action in reliance on it. However, if this consent was granted to show satisfaction of a legal or court order, then this permission cannot be revoked until that order has been satisfied.

TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

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### THE VIICAL HEALTH DESCRIPTION

PO Box 114 Red Lake, MN 56671

Phone: (218) 679-3321

FAX: (218) 679-2727



# AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>GENERIC<

	QUEST THAT THE RED LAKE
CHEMICAL HEALTH PROGRAMS RELEASE:	
. (TYPE OF INFORMATION/DOCL	JMENT)
TO	
*(AGENCY OR INDIVIDUAL'S NAME & PH	HONE NUMBER)
FOR THE PURPOSE OF:	0000 <b>1</b>
(REASON OR PURPOSE) A willfully false statement or representation is a criminal offer \$10,000, or minimum imprisonment of 5 years, or both. (U.S. Code, title 18, section 1001, formerly section 80)	nse punishable by maximum fine of
X	
*SIGNATURE OF APPLICANT (Patient, next of kin, adm IF OTHER THAN PATIENT INDICATED RELATIONSHI	ninistration of estate, etc.) IP OR AUTHORITY.
*CONTACT PHONE OR ADDRESS OF APPLICANT	X *NATÉ

This consent is subject to revocation at any time except to the extent that Chemical Health Programs has already taken action in reliance on it. However, if this consent was granted to show satisfaction of a legal or court order, then this permission cannot be revoked until that order has been satisfied.

TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

NOTE: Public Health Service Act 42. U.S.C Section 290dd-2, previously recognized as 42 C.F.R, Part 2, protects the confidentiality of all individual, client data. Any disclosure of information, which is not authorized by those regulations, is subject to a fine of not more than \$500 in the case of a first offense and not more than \$5,000 in the case of each subsequent offense. Violations can be reported to the United States Attorney for the District of Minnesota, 300 South 4th street, Number 600, Minneapolis, MN 55415 or to the Substance Abuse and Mental Health Service Administration, 5600 Fisher's Lane, Rockville, MD 20857 or 1-800-SAMSHA-7 (877-726-4727 or TTY 1-800-487-4899).

## CHEVICAL HEALTH PROCEAMS

PO Box 114 Red Lake, MN 56671

Phone: (218) 679-3321

FAX: (218) 679-2727



#### AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>TREATMENT and CARE COORDINATION<<

	=======================================
1	
X *(Client's Name) REQUEST THAT T	HE RED LAKE
CHEMICAL HEALTH PROGRAMS RELEASE: Rule 25 Recommendation and Assessment Packet, as well as care coordination information.	d Statewide Uniform
(TYPE OF INFORMATION/DOCUMENT) TO	
*(AGENCY OR INDIVIDUAL'S NAME & PHONE NUMBER)	
FOR THE PURPOSE OF: Treatment planning and Care Coordination	
(REASON OR PURPOSE)	
I also REQUEST THAT	
*(AGENCY OR INDIVIDUAL'S NAME)	
Release to RED LAKE CHEMICAL HEALTH PROGRAMS weekly treatment progress repor revisions, attendance and status in treatment, case management information, any other the coordination of various aspects of my care, and termination summary for the purpose of	formation relevant to
A willfully false statement or representation is a criminal offense punishable by maximum imprisonment of 5 years, or both.  (U.S. Code, title 18, section 1001, formerly section 80)	m fine of \$10,000, or
X	
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.	e, etc.)
*CONTACT PHONE OR ADDRESS OF APPLICANT	
A "UAIF	
This consent is subject to revocation at any time except to the extent that Chemical Health I taken action in reliance on it. However, if this consent was granted to show satisfaction of a then this permission cannot be revoked until that order has been satisfied.	Programs has already a legal or court order,

then this permission cannot be revoked until that order has been satisfied.

TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

NOTE: Public Health Service Act 42. U.S.C Section 290dd-2, previously recognized as 42 C.F.R, Part 2, protects the confidentiality of all individual, client data. Any disclosure of information, which is not authorized by those regulations, is subject to a fine of not more than \$500 in the case of a first offense and not more than \$5,000 in

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FAX: (218) 679-2727



#### AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>RED LAKE FAMILY & CHILDREN SERVICES (OMBIMINDWAA)<<

*(Client's Name) REQUEST THAT THE RED LAKE	
CHEMICAL HEALTH PROGRAMS exchange: Information on legal history and child welfare investigations including complaints, nature of abuse or neglect reported, charges and court orders and Rule 25 Recommendation. Compliance with Results, and any Treatment Dates.  (TYPE OF INFORMATION/DOCUMENT)	-
TO: RED LAKE FAMILY & CHILDREN SERVICE (OMBIMINDWAA) AND RED LAKE NATION	
*(AGENCY OR INDIVIDUAL'S NAME & PHONE NUMBER)	
FOR THE PURPOSE OF: <u>Understand the nature of referral for assessment, develop a full assessment picture, and demonstrate Compliance with Court Orders</u> (REASON OR PURPOSE)  A willfully false statement or representation is a criminal offense punishable by maximum fine of 5 years, as both as a criminal offense punishable by maximum fine of 5 years, as both.	
(U.S. Code, title 18, section 1001, formerly section 80)	
Χ	
*SIGNATURE OF APPLICANT (Patient, next of kin, administration of estate, etc.)  IF OTHER THAN PATIENT INDICATED RELATIONSHIP OR AUTHORITY.	
*CONTACT PHONE OR ADDRESS OF APPLICANT	
∧ °DATE	
This consent is subject to revocation at any time except to the extent that Chemical Health Programs has already taken action in reliance on it. However, if this consent was granted to show satisfaction of a legal or court order, then this permission cannot be revoked until that order has been satisfied.	
TO EVEN SECOND S	

TO EXPIRE ONE YEAR FROM DATE MENTIONED ABOVE.

NOTE: Public Health Service Act 42. U.S.C Section 290dd-2, previously recognized as 42 C.F.R, Part 2, protects the confidentiality of all individual, client data. Any disclosure of information, which is not authorized by those regulations, is subject to a fine of not more than \$500 in the case of a first offense and not more than \$5,000 in the case of each subsequent offense.

PO Box 114 Red Lake, MN 56671

Phone: (218) 679-3321

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#### AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>RED LAKE NATION COURTS<<

	114110N COURTS<<
火 *(Client's Name)	REQUEST THAT THE RED LAKE
CHEMICAL HEALTH PROGRAMS RELEAS	Ε:
Rule 25 Recommendation. Compliance v (TYPE OF INI	with Results, and any Treatment Dates. FORMATION/DOCUMENT)
TO: RED LAKE NATION COURTS	
*(AGENCY OR INDIVIE	DUAL'S NAME & PHONE NUMBER)
FOR THE PURPOSE OF: <u>Demonstrate Con</u>	npliance with Court Orders ON OR PURPOSE)
A willfully false statement or representation is a comminimum imprisonment of 5 years, or both. (U.S. Code, title 18, section 1001, formerly section	Criminal offense punishable by mayiraya 5
X	
*SIGNATURE OF APPLICANT (Pat IF OTHER THAN PATIENT IND	tient, next of kin, administration of estate, etc.) NICATED RELATIONSHIP OR AUTHORITY.
*CONTACT PHONE OR ADDRESS OF APPLICANT	
	A *DATE
This consent is subject to revocation at any tim	16 except to the sixteet the six

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# AUTHORIZATION FOR DISCLOSURE OF CLIENT INFORMATION >>OTHER COURTS<<

>>OTHER COURT	-S<<
[	
X *(Client's Name)	REQUEST THAT THE RED LAKE
CHEMICAL HEALTH PROGRAMS RELEASE:	· ·
Rule 25 Recommendation, Compliance with Results (TYPE OF INFORMATION)	s. and any Treatment Dates. /DOCUMENT)
TO:	
*(ÁĞENCŸ OR INDIVIDUAL'S NAMI	E & PHONE NIMBED
FOR THE PURPOSE OF: <u>Demonstrate Compliance wit</u> (REASON OR PURP	th Court Orders
A willfully false statement or representation is a criminal offen minimum imprisonment of 5 years, or both.  (U.S. Code, title 18, section 1001, formerly section 80)	se punishable by maximum fine of \$10,000, or
X	
*SIGNATURE OF APPLICANT (Patient, next of k IF OTHER THAN PATIENT INDICATED RELAT	in, administration of estate, etc.) FIONSHIP OR AUTHORITY.
*CONTACT PHONE OR ADDRESS OF APPLICANT	A
	X *DATE
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