

THE COUNSELING SERVICE

**SOUTH DAKOTA SCHOOL OF MINES & TECHNOLOGY, ROOM 6, SURBECK CENTER
RAPID CITY, SOUTH DAKOTA 57701, PHONE 605-394-1924**

INFORMATION REQUEST

I, _____, hereby authorize
_____, to disclose the
(name and address of person and/or agency)
information checked below to The Counseling Service.

INFORMATION RELEASE.

I, _____, hereby authorize
The Counseling Service to release the information checked below to

(name and address of person and/or agency)

A Counseling Service staff member has explained to me: who is to receive this information, and the type of information to be requested/released.

RECEIVER OF INFORMATION PURPOSE

_____ CS Staff
_____ Other

_____ To assist in my
treatment
_____ To assure adequate
coordination of
treatment efforts
_____ Other

TYPE OF INFORMATION

_____ Medical and treatment
information
_____ Treatment plan information
_____ Psychological testing
and evaluation
_____ Discharge summary
_____ School Records
_____ Other (specified)

My authorization in this matter is given for the following time period: _____
And will not be valid after the end of this period unless I renew the authorization.

I understand that I may cancel this authorization at any time, except that I cannot
Cancel actions taken on the basis of information given out prior to cancellation.

SIGNATURE OF CLIENT: _____ DATE: _____

SIGNATURE OF WITNESS: _____ DATE: _____