DAKOTA COLLEGE AT BOTTINEAU

Counseling Services
Release of Information

I, _____DOB_____, hereby give DCB Counseling Services/Corey Gorder, MS, LPCC/Melissa Kornkven, LMSW permission to *share* and *receive* the following personal health information in either written, verbal, or electronic forms.

_____Intake notes
_____Progress notes
_____Academic information
_____Psychological evaluation
_____Treatment summary
_____Confirmation of attendance
_____Medical information
_____Information about alcohol and drug usage including history of treatment and assessment
_____All information in my chart to include the categories listed above.
_____Other

I agree to have the aforementioned information shared with:

_____Class instructors
_____Coaches
_____DCB administration
_____St Andrews Health Center
_____Health Care Campus
_____Parents
_____Consent to release information from DCB Counseling Services to myself
_____Exclusions
_____Other

I understand that no disclosure of my records can be made without my written consent, unless otherwise provided for in legal statutes or judicial decisions. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken upon this release. An electronic reproduction of this document is as valid as the original. I acknowledge that I am aware that this release of information expires upon one year from the signature date below unless specifically requested otherwise in writing.

_____ _____
Student/Client signature Date

_____ _____
Witness Date