Disability Services

1105 W. 8th St.
Yankton, SD 57078
605-668-1518

Release of Information

I, ____, hereby authorize Mount Marty Student Counseling Center, 1105 W. 8th St, Yankton, SD 57078

☐To receive the following information from my medical records from the facility listed below

☐To exchange verbal information with the facility listed below

Name/Facility____
Address____
City, State, Zip____
Phone____

To Be Disclosed:

☒Diagnosis ☒Prognosis

☒My Identity as a Client ☒Progress Notes/Summary

☒Discharge Summary ☒Assessment

☒Intake ☒Recommendation

The purpose of this disclosure is:

☒Further treatment ☒Obtaining Collateral Information

☐Other____

I understand that I may revoke this consent at any time except to the extent that action based on the consent has been taken. The consent will expire one year after the date signed below.

____

Client Signature Date Client's Date of Birth

_______________________________________ ___________________________

Witness Signature Date

Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless specific written consent has been obtained by the person to whom it pertains, or as otherwise permitted by such regulations. A general release of information is not sufficient for this purpose.