KEYSTONE
COUNSELING & CONSULTING

Phone: 320-234-0240
adam@keystonecounselingmn.com

School District #2687 In-School Counseling Referral Form

Parent/guardian please fill out the information below along with the signed release of information form. Please return both forms to your child's school designated point of contact person either:

Jessica Larson , Winsted SW
Emily Holm, HS Counselor
Andraya Parenteau, MS Counselor
Breanne Adickes, Waverly SW

Today's date: _____

Name of student: _____ DOB: _____

School attending? ☐ HLWW High School ☐ HLWW Middle School
☐ Humphrey Elementary ☐ Winsted Elementary

Grade? ☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th
☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th

Parent/Guardian name: _____

Parent/Guardian phone: _____

Parent/Guardian Email: _____

Please provide the best way and time of day to contact you:

Briefly share the reasons you are seeking therapy/counseling:

Thank you! Someone will reach out to you soon to set up the initial intake session.

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION FOR SCHOOL

KEYSTONE
COUNSELING & CONSULTING

Client name: _____ DOB: _____

Address: _____

I, _____, authorize Keystone Counseling and Consulting to receive and release information from/to:

Independent School District No. 2687, Howard Lake, Waverly, Winsted, Minnesota ("School District").

8700 County Rd. 6
PO Box 708
Howard Lake, MN 55349
(320) 354-3900 ext. 1000

Information to be released/shared includes (check all that apply):

____ All Records ____ Ongoing Communication ____ Diagnostic Report ____ Testing Results
____ Psychological Eval. ____ Progress Report ____ Chemical Evals. ____ Psychiatric Evaluations
____ Treatment Plan ____ Medical History ____ School Records ____Family History
____ Other _____

Information will be released by (check all that apply):

____Telephone ____Written ____ Unsecure Email ____ Fax ____ In-person

This release is required for the purpose of (Check all that apply):

____ Continuation of Services ____ Planning Appropriate Treatment ____ Continue/Follow-up Care
____ Social Services Involvement ____ Additional Care ____ Seeing Student a School
____ Other _____

I recognize that Keystone Counseling and Consulting cannot guarantee the privacy of information released by it under this authorization, but it is our intent that the party I authorize to receive it will consider it private. I understand the information released may be subject to release by the person(s)/agency receiving it and no longer protected by the federal privacy regulations. I also understand that l may revoke this authorization by notifying my therapist at Keystone, in writing, of my desire to revoke it. However, l understand that if l revoke this authorization, it will not have any effect on actions taken by Keystone in reliance on it before I revoke it. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment. A photocopy of this authorization will be treated in the same manner as the original.

_____

Signature of Client Date

_____

Signature of Parent/Guardian Date

_____

Signature of Therapist Date