Counseling Center
VALDOSTA STATE UNIVERSITY
STUDENT HEALTH CENTER, SECOND FLOOR
VALDOSTA, GA 31698
229-333-5490 FAX-229-253-4113

Name_____
VSU ID#_____
DOB_____
TELEPHONE_____

AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION

This form is for students who are being referred to Christie Campus Health by the VSU Counseling Center and may receive follow up assistance by Case Management to ensure continuity of care. All students referred to Christie Campus Health are asked to sign an authorization for the sharing of information. Only necessary information will be shared.

I, _____, hereby authorize the sharing of my records and information between the following
(Print Full Name)
departments and organizations for the purpose of this referral:

VSU Counseling Center	Case Management	Christie Campus Health
Phone: (229) 333-5940	Phone: (229) 259-2084	Phone: (781) 457-7700

Purpose of disclosure: Referral for services_____
Information to be released: That necessary for referral and ongoing care_____

Please check below whichever may apply.

_x_ The Counseling Center may consult with the above-named individuals via phone, email, and/or in person.

Treatment, payment, enrollment for benefits, or eligibility may not be conditioned on whether this authorization is signed and not revoked.

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to The Counseling Center to disclose my records, and that I may revoke this Authorization, except if this authorization was obtained as a condition of obtaining insurance coverage, at any time by providing a written notice to The Counseling Center to the attention of the Custodian of Records. The revocation shall be effective except to the extent that The Counseling Center has already used or disclosed information in reliance on the Authorization. I understand that my information may be re-disclosed by the authorized person/organization receiving this information, and at that point, that the information attached here to will no longer be protected by HIPAA privacy regulations.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I do NOT authorize The Counseling Center to disclose any of the following information. (Please initial)

_____AIDS/HIV _____Sexually Transmitted Diseases

Please refer to Notice of Health Information Privacy Practices, at www.valdosta.edu/legal/hipaa, for more detailed information. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: the earlier of graduation, dropout, transfer, or termination by patient in writing.

I understand that the University System Office of the Board of Regents of the University System of Georgia and Valdosta State University assume no responsibility for the use or misuse by others of my records or information released under this document. I release the Board of Regents of the University System of Georgia and its agents and employees from all legal liability that may arise from this authorization.

Signature_____ **Date_____**

_____ **Date_____**

(Signature of Witness) **(Title or Relationship To Client)**

The above authorization is given on this client's behalf because the client is a minor or is unable to sign for the following reasons:
_____.

Signature_____ Date_____
(Relative/Guardian/Personal Representative)
Date copy given to client_____
Processed by_____ Date_____