THE 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

I, _____, hereby authorize The Counseling Center, Valdosta State University, to
(Print Full Name)
RELEASE my records and information to the following individual or organization:
Name/ Organization: ___Legacy Behavioral Health Services_____
Address:_____3120 N. Oak Street Ext., Ste B_____
_____Valdosta, GA 31602_____
Phone: _____ Fax #:_____
Purpose of disclosure: _____Coordinate Services_____
Information to be released: ____Information necessary for consultation_____
Please check below whichever may apply.

___ I will pick up the copies myself (allow 48 hours for processing and please bring a picture ID to pick up)
___Please fax the copies to the fax number above
___The Counseling Center may consult with the above-named individual via phone 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_____