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)

Purpose of disclosure: _____Coordinate Services_____
Information to be released: ____Information necessary for consultation_____

Please check below whichever may apply.

___ I want a copy uploaded to my Student Health Portal.
___ I will pick up the copies myself (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