THE COUNSELING CENTER
VALDOSTA STATE UNIVERSITY
STUDENT HEALTH CENTER, SECOND FLOOR

Name: ____________________
VSU ID#: __________________
DOB: _____________________

RELEASE my records and information to the following individual or organization:
Name/ Organization: ___Office of Student Affairs____
Address:_______________Valdosta State University____
____
Phone: ___(229)333-5941_________________________Fax: (229)245-6481____________________________
Purpose of disclosure: ______________________________________
Information to be released: Information necessary for letter_____________________________________

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