

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)

REL to be released necessary for referral and ongoing care _____

Please check below whichever may apply.

The Counseling Center may consult with the above 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 disclosed information to a third party. The revocation shall not be effective if the information has been disclosed to a third party.
