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: GAP Program
Address: Valdosta State University 1500 N Patterson St Valdosta, GA 31698
Phone: 229-253-4113 Fax #:_____
Purpose of disclosure: Referral for GAP services
Information to be released: Information necessary for referral

Please check below whichever may apply.

___ I want a copy uploaded to my Student Health Portal.
___ 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
_X_ The Counseling Center may consult with the above-named individual via phone/e-mail/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.

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_____