

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 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 providing a written notice to The Counseling Center to the attention of the Custodian of Records. The revocation shall be effective 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 redisclosed by the authorized person/organization receiving