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: _____South Georgia Medical Center_______________________________________
Address:____________________2501 N. Patterson St.______________________________________
_____Valdosta, Ga. 31602____
Phone : _______(229) 333-1000________________ Fax #:______________________________
Purpose of disclosure:__________Continuity of care_________________________________
Information to be released: _Information related to hospitalization______________________

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, excem[t)1.6 (s)-2 (l)1.6 (s)-2 (l)1.r(t)1.6 (h)-2.7(is)-2 (a)-3.8.1 (y n)-2.4ueecotive lgxzatio,to/nthebxte2n(l)1.5 Tll)28.6 (sTc 0 T37.19t)1 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 fficeNOTthe 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______________________

Processed by_______________________________ Date_______________