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 for 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 redisclosed by the authorized person/organization receiving