THE COUNSELING CENTER
VALDOSTA STATE UNIVERSITY
STUDENT HEALTH CENTER, SECOND FLOOR

Name: _____
VSU ID#: _____
DOB: _____

RELEASE my records and information to the following individual or organization:
Name/ Organization: Office of Student Affairs
Address: Valdosta State University

Phone: (229)333-5941 Fax: (229)245-6481
Purpose of disclosure: _____
Information to be released: Information necessary for letter

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.

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 do NOT authorize The Counseling Center to disclose any of the following information. (Please initial)

_____AIDS/HIV _____Sexually Transmitted Diseases