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)

REL to be Tbeleasedessary for referral and ongoing care _____ ____

_____

Please check below whichever may apply.

_X_The Counseling Center may consult with the athisvauthorization 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 Counselingok0.7 (it)-13.3 6.40.7 0.14.1.6 (u.4 (t)1.M0.7 c-2.4 (t)1.7 (er)0.0 Tc 0 Tw 4.216 0 Td[()]TJ-0.003 Tc 0.003 Tw 0.199 0 Td[(r))-1.6 (t)]TJ0 Tc 0 Tw 0.

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