THE COUNSELING CENTER
VALDOSTA STATE UNIVERSITY
STUDENT HEALTH CENTER, SECOND FLOOR
VALDOSTA, GA 31698
229-333-5490FAX229-253-4113

Name	
VSU ID#	
DOB	
TELEPHONE	

AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION	
l,, hereby authorize The Counseling Center, Valdosta State University, to	
(Print Full Name)	
RELEASE my records and information to the folloimidigidual or organization:	
Name/ Organization: <u>Legacy Behavioral Health Services</u>	
Address: 3120 N. Oak Street Ext., Ste B	
Valdosta, <b>3</b> #602	
Phone: Fax #:	
Purpose of disclosure:Coordinate Services	
Information tobe 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 aboureed individual via phone and/or in person	

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorizationuseling Center to disclose my records, and that I may revoke this Authorization, exidents 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 the exicept to the extent that he Counseling Center has already used or disclosed information in reliance on the Authorization. I understand that my information receiving

Treatment, payment, enrollment for benefits, or eligibility may not be conditioned on whether this auatiorize signed and not revoked.