THOMAS E. COOK COUNSELING CENTER
VIRGINIA TECH
220 GILBERT STREET, SUITE 2400
BLACKSBURG, VA 24061-0108
PHONE (540) 231-6557 FAX (540) 231-2104

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ do hereby request that the Thomas E. Cook Counseling Center of Virginia
Name (Print)
Tech engage in the following as it relates to my records.

In accordance with this request, I hereby release and forever discharge and agree to hold harmless and indemnify the Commonwealth of Virginia, Virginia Tech, the Thomas E. Cook Counseling Center administration and staff, and all other officers, agents and employees of the University from any and all claims, demands, damages, actions or suits of law or in equity of whatever kind which might arise in accordance with my request.

Purpose of Disclosure:

____Continued care
____Employment
____Legal
____Personal knowledge
____Insurance
____Other_____

Additional information about purpose of disclosure:

_____

Check all desired:

_____Please have the following information **from** an outside person/provider/agency conveyed to the Thomas E. Cook Counseling Center.
_____Please have the Thomas E. Cook Counseling Center convey the following information **to** an outside person/provider/agency (allow 2 weeks to process).

COUNSELING RECORDS

- ☐ Dates of Treatment
- ☐ Treatment summary
- ☐ Other (please explain below)

_____

PSYCHIATRY/MEDICAL RECORDS

- ☐ Dates of Treatment
- ☐ Initial Evaluation
- ☐ Last Clinical Visit Note
- ☐ Lab results
- ☐ Diagnosis
- ☐ Other (please explain below)

How would you like this information communicated? ____Written information ____ Verbal Discussion
Please: ☐ print for pick up ☐ send via encrypted email ☐ send via fax ☐ send via mail ☐ call

_____
Outside person/provider/title

_____
Name of agency/affiliation/relationship

_____
Mailing address: street, city, and zip code

_____
Phone and fax number

I understand this authorization is voluntary and not a condition of treatment. This authorization is automatically void after 1 year, and may be terminated by me at any time with a written notice, effective as of the date of signature. Information sent and/or received through this authorization may not be re-released to another individual or agency.

I may revoke authorization at any time, but my revocation is not effective until delivered in writing to the Cook Counseling Center and is not effective as to health records already disclosed under this authorization. A copy of this authorization and notation concerning the persons or agencies to which disclosure was made will also be included with my original health records.

I understand that although Cook Counseling Center is not a covered entity as pertains to HIPAA regulations, the counseling center respects and restricts access to records for my confidentiality.

I understand Cook Counseling Center cannot respond to background checks or security clearance questionnaires which require assessment and/or prediction of behaviors regarding a person's fitness to safeguard national security information. We will, however, provide dates of treatment, diagnoses, and presenting concerns at Cook Counseling Center.

I understand that Cook Counseling Center recommends a treatment summary for third party requests (non-health care providers). You are entitled to request your health records and if you choose to share your records with third party individuals (non-health care providers) there may be risks to how clinical information is interpreted and used to make decisions on my behalf.

I understand that I may ask to see copies of my health record as well as information about any disclosures that were made.

I understand that it is possible that protected health information disclosed pursuant to this authorization may be redisclosed by the recipient. Redisclosed protected health information may no longer be protected by HIPAA and other privacy regulations.

I understand there is a $10.00 fee for requesting appointment dates and $20.00 for treatment summary.
****Fee is waived when records are requested for other health care professionals for the purpose of continuity of care.***

_____***Please initial to indicate you understand that the release of your records may include information related to substance use which is protected by Federal Regulations (42 CRF Part 2) and requires specific written authorization for such disclosure. Federal Regulations restrict use of any disclosure from being used in criminal investigations.***

_____	_____
Name of student (print)	Phone number of student
_____	_____
Signature of student	Date
_____	_____/_____/_____
Student identification number	Date of birth
_____	_____
CCC staff witness	Date

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office use only **s**can only: ☐ sent records: ☐ requested records: ☐ records fee paid: ☐ no fee/records for continuity of care: ☐

Information released:_____

Signature: _____ Date:_____