AUTHORIZATION FOR RELEASE OF INFORMATION

I, __________________________, do hereby request that the Thomas E. Cook Counseling Center of Virginia 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    ___ Personal knowledge
___ Employment       ___ Insurance
___ Legal            ___ 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

___ Treatment summary
___ Diagnosis
___ Treatment recommendations
___ Dates of treatment
___ Testing results
___ Other
___ Exclusions (items not to be disclosed)

PSYCHIATRY/MEDICAL RECORDS

___ Initial evaluation
___ Progress notes
___ Last clinical visit note
___ Lab results
___ Diagnosis
___ Dates of treatment
___ Other

How would you like this information communicated?

___ Verbal discussion
___ Written information
___ Other
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.

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) 

Signature of student 

Student identification number 

CCC staff witness 

Phone number of student 

Date 

Date of birth 

Date 

office use only  

scan only: ☐  sent records: ☐  requested records: ☐  

Information released: 

Signature: ___________________________ Date: ___________________________