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
___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

___Treatment
___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

Form Revised 06/07/2021
I understand this authorization is voluntary and not a condition of treatment. This authorization is automatically void after one (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 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)  Phone number of student

Signature of student  Date

Student identification number

Date of birth

CCC staff witness  Date

Information released: _____________________________________________________________________________________________________________

Signature:_________________________________________________________________________date:_________________________