**THOMAS E. COOK COUNSELING CENTER**

**MCCOMAS HALL, RM 240, VIRGINIA TECH**

**895 WASHINGTON STREET**

**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 \_\_\_\_Personal knowledge

\_\_\_\_Employment \_\_\_\_Insurance

\_\_\_\_Legal \_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional information about purpose of disclosure:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_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).

**Check all desired**:

**COUNSELING RECORDS**  **PSYCHIATRY/MEDICAL RECORDS**

\_\_\_\_\_Treatment summary \_\_\_\_\_Initial evaluation

\_\_\_\_\_Diagnosis \_\_\_\_\_Progress notes

\_\_\_\_\_Treatment recommendations \_\_\_\_\_Last clinical visit note

\_\_\_\_\_Dates of treatment \_\_\_\_\_Lab results

\_\_\_\_\_Testing results \_\_\_\_\_Diagnosis

\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Dates of treatment

\_\_\_\_\_Exclusions (items not to be disclosed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you like this information communicated?

\_\_\_\_Verbal discussion

\_\_\_\_Written information

\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

name of client (print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

signature of client date

\_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

student identification number date of birth

\_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

social security number phone number of client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

witness date

office use only:

scan only:

requested records:

information released:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

revised 08/07/14