Office of Student Support
4400 University Drive, MSN 6C9
Student Union Building I, Suite 4100
Fairfax, VA 22030

Release of Information Authorization

Student Name _____ **Student ID** G_____

Student Address _____ **Student Phone** (_____)_____

_____

COUNSELING & PSYCHOLOGICAL SERVICES
Student Union Building I, Room 3129 ● 703.993.2380 (phone) ● 703.993.2378 (fax)

To give you prompt assistance, Counseling and Psychological Services (CAPS) may need to request or furnish information to health professionals or other sources. We ask you to authorize in writing the release of such information. At all times, CAPS is committed to safeguarding your rights and wellbeing. Virginia Code §23-9.2:3 requires that parents be notified if a dependent student presents a substantial likelihood of danger to self or others. To carry out these legal requirements, the Dean of Students Office may be notified of this danger. The Dean of Students will make the decision regarding parent notification.

I authorize George Mason University Counseling and Psychological Services to furnish information about _____ to the Dean of Students Office of Student Support and/or its designees for the purpose of effective coordination of support services for my success as a Mason student.

I understand that the information being released is to be kept strictly confidential. It may only be used for the above stated purpose and no one other than the above parties may have access to this information (Virginia Code exceptions may apply). I understand that I may issue a written revocation of this permission at any time. This authorization extends for **one year** from the date I sign this document, unless otherwise specified here: _____

_____ _____
Student Signature Date

_____ _____
Witness Name Witness Occupation

_____ _____
Witness Signature Date

CONFIDENTIAL INFORMATION NOT TO BE REDISCLOSED The Virginia Patient Health Records Privacy Statue (§32.1-127.1:03) states that "No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure."

STUDENT HEALTH SERVICES
Student Union Building I, Room 2300 ● 703.993.2831 (phone) ● 703.993.4365 (fax)

I authorize the staff at George Mason University Student Health Services to discuss my medical condition(s) with and disclose any medical records to the Dean of Students Office of Student Support and/or its designees for the purpose of effective coordination of support services for my success as a Mason student. This authorization extends for **one year** from the date I sign this document, unless otherwise specified here: _____

_____ _____
Student Signature Date

_____
Witness Name

_____ _____
Witness Signature Date

CONFIDENTIAL INFORMATION NOT TO BE REDISCLOSED The Virginia Patient Health Records Privacy Statue (§32.1-127.1:03) states that "No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure."

OFFICE OF DISABILITY SERVICES
Student Union Building I, Room 2500 ● 703.993.2474 (phone) ● 703.993.4306 (fax)

I understand that the staff of the Office of Disability Services (ODS) at George Mason University will have access to my disability records, as well as other academic records. I further understand that in order to meet my educational needs, it may be necessary for ODS to contact other campus departments and/or individuals on an as needed basis.

I authorize the professional exchange of academic accommodations and specifics of my disability for purpose of planning and providing quality services between ODS staff and the Dean of Students Office of Student Support and/or its designees.

_____ _____
Student Signature Date

_____ _____
Witness Name Witness Occupation

_____ _____
Witness Signature Date