CONFIDENTIAL

STUDENT HEALTH & UNIVERSITY COUNSELING CENTER

STUDENT ACCESSIBILITY OFFICE (SAO)

INITIAL CONTACT

NAME: _____ ID#: V00_____ SEX: _____ DOB: ____/____/_____

Date enrolled into VSU: Fall/Spring _____ Insurance? Yes or No Insurance Provider: _____

Campus Address: _____

Room # Residence Hall Box # Room Phone #

Permanent Address: _____

Street City/State Zip Code

Home Phone: _____ Cell Phone: _____

VSU Email: _____ Email: _____

PREFERRED METHOD OF CONTACT (please select one): □ Phone □ Email □ Mail

Who referred you to SAO? _____

How did you hear about our services? _____

CURRENT EDUCATIONAL STATUS: Please circle your classification as of today.

Classification/Credit Hours: FRESHMAN (<30) SOPHOMORE (30-59) JUNIOR (60-89) SENIOR (90+) GRADUATE STUDENT

Major: _____ Minor(s): _____ Are you currently having problems in class? Yes / No

Reason for visit: _____

_____

_____

Have you received help with this problem before? Yes / No If yes, when was the last time? _____

Do you have any concerns that may interfere with your studies at VSU? Please circle those that apply to you today.

Stress Finances Family Problems Relationship Problems Substance Use/Abuse
Legal Issues Sexual Assault Other: _____

STUDENT SIGNATURE: _____ DATE: _____

FOR COUNSELING STAFF TO COMPLETE: Indicate type of referral made, if any. Was an appointment scheduled? Summarize visit. (Must be completed in its entirety and signed by a UCC staff member or trainee.)

_____Student Support Services

_____Academic Support Center

_____Student Accessibility Office

_____Financial Aid Office

_____Outpatient/External referral

_____Personal Counseling _____Appt. Date

_____Substance Abuse Counseling

_____Crisis Counseling and MSE

Summary:_____

_____

_____

_____

Revised 9/10/18

Staff Signature: _____ Date: _____

STUDENT HEALTH & UNIVERSITY COUNSELING CENTER

STUDENT ACCESSIBILITY OFFICE (SAO)

CONSENT TO RELEASE INFORMATION

NAME: _____ V#: _____

I hereby authorize Virginia State University Counseling Center (UCC) Student Accessibility Office (SAO) to release and receive information concerning the above-named person to/from:

_____

(Name of Person or Organization)

_____

(Address)

_____

(Telephone and Fax Number)

Specify the type of information to be disclosed or exchanged:

- ☐ Assessment
- ☐ Attendance
- ☐ Treatment Summary
- ☐ Testing Reports
- ☐ Recommendations
- ☐ Disability Documentation
- ☐ Psychological Records
- ☐ Medication
- ☐ Psychiatric Evaluation
- ☐ Court Proceedings/Legal Records
- ☐ Education Evaluation Information
- ☐ Medical/Physical Evaluation
- ☐ Treatment/Discharge Summaries
- ☐ Substance Abuse Treatment
- ☐ Social History
- ☐ Acknowledgement of Client's Presence in Treatment
- ☐ Progress Notes
- ☐ Disability Related Documentation
- ☐ Other

I understand that the information is to be used for:

- ☐ Academic Consideration
- ☐ Aftercare Planning
- ☐ Contact with Referral Source
- ☐ Family Involvement
- ☐ Continuity of Treatment
- ☐ Other: _____

I understand that I can withdraw this consent at any time by contacting SAO in writing at the address below. These records may be released via fax machine, secure email, written correspondence, telephone, or in person communication. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records.

This consent expires at the end of the academic year unless another date is specified: _____ (Date)

Signature: _____ Print Name: _____

Phone Number: _____ Date: _____

This form contains this students' identifiable information and is intended for review and use for no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form as a mistake, please send it to the address below:

Mail the original request form to : Virginia State University

University Counseling Center Student Accessibility Office

PO Box 9030

Petersburg, VA, 23806

STUDENT HEALTH & UNIVERSITY COUNSELING CENTER

STUDENT ACCESSIBILITY OFFICE (SAO)

CONSENT TO RELEASE INFORMATION

NAME: _____ V#: _____

I hereby authorize Virginia State University Counseling Center (UCC) Student Accessibility Office (SAO) to release and receive information concerning the above-named person to/from:

VSU Faculty/Staff

(Name of Person or Organization)

VSU Campus

(Address)

Numbers will vary

(Telephone and Fax Number)

Specify the type of information to be disclosed or exchanged:

- ☐ Assessment
- ☐ Attendance
- ☐ Treatment Summary
- ☐ Testing Reports
- ☐ Recommendations
- ☐ Disability Documentation
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CONSENT TO RELEASE INFORMATION

Regarding Our Information Forms and Service

The purpose of the following informational questionnaires is to obtain as comprehensive a picture of your background and concerns as possible so that we may best service your needs. Please answer the questions as honestly and accurately as you can. All records at the Counseling Center Student Accessibility Office are confidential.

Regarding Confidentiality

We realize that the concerns you bring to our office are highly personal in nature. We assure you that all of the information shared both verbally and in writing will be managed within the legal and ethical conditions of confidentiality. This means that information will not be released to anyone except under the following conditions:

1. When our counseling staff feel the need to seek supervision, we may consult with professional colleagues within our agency. This will aid us in our work with you.
2. If we believe that you pose a life-threatening risk to yourself or someone else, we must notify responsible individuals to prevent any harm from occurring.
3. If you are under 18 years of age and the victim of physical or sexual abuse, we are required to report relevant information to child protective services to prevent further abuse from occurring. Additionally, if you disclose information regarding the physical or sexual abuse of a minor, we are also required to report relevant information to child protective services.
4. If you are involved in a legal action and a judge determines that clinical information will provide evidence bearing significantly on the case, he or she may subpoena or legally compel the therapist to release information from your records.
5. In case of any malpractice action against counselors on staff, the counselor may disclose information from the case that is necessary or relevant to the counselor's defense.
6. When your counselor is receiving supervision, a consent form to discuss your case with the supervisor will be fully discussed and signed giving your consent to this.
7. For the purpose of evaluating our services, gathering valuable research information, and designing future programs, the Counseling Center Student Accessibility Office staff may utilize your clinical information; however, your anonymity will be maintained through the use of a client identification number, which is different from any identifying data such as a social security or student ID number.
8. All counseling records may be stored on a secured computer system. n If this occurs, confidentiality will be maintained through Novell Security and database security roles.
9. All case files are the property of the University Counseling Center Student Accessibility Office.

In all other situations, information may be released to appropriate individuals or agencies **ONLY UPON YOUR WRITTEN REQUEST**.

I have read and understand that these conditions of confidentiality apply to being identified as a client, as well as any information shared verbally or in writing to my counselor.

_____ _____

(Date) (Signature)

If you have any questions about this form, your intake counselor will be glad to discuss the information with you.