



If the Marshall University Psychology Clinic is to **RELEASE** information, it should be sent to (please complete as much as possible):

Name of institution or individual \_\_\_\_\_

Address

\_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip Code)

Phone #: (\_\_\_\_\_) \_\_\_\_\_ Fax #: (\_\_\_\_\_) \_\_\_\_\_  
(area code) (area code)

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If an institution or individual outside of the Marshall University Psychology Clinic is to forward information for the Marshall University Psychology Clinic to **RECEIVE**, the institution or individual can send that to:

Marshall University Psychology Clinic

Attn: \_\_\_\_\_

One John Marshall Dr.

Huntington, WV 25755

Fax: (304) 696-2784

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Marshall University Psychology Clinic. However, my request to revoke the authorization will not be in effect to the extent that information has already been disclosed as a result of this authorization or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that the Marshall University Psychology Clinic generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient of my information and is no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_  
Client or Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If a representative of the client, describe your authority to act for the client  
(e.g. parent, legal guardian, power of attorney, etc.)