

**Marshall University Psychology Clinic
Release of Information/Authorization Form**

Client Name _____
Social Security # _____ Date of Birth _____
Address _____

(Street) Phone #: (_____) _____

(City) (State) (Zip Code)

Please mark ("X") the appropriate blank(s)

I authorize _____ and their representatives or staff to disclose the following information, if such information exists:

- _____ medical information
_____ clinical/psychological information
(*if authorization is for the use and/or disclosure of psychotherapy notes, then it needs a separate release and cannot be combined with any other authorization)
_____ all of the medical, clinical/psychological, and other information that may pertain to my care
_____ specific information that may pertain to my care as listed below:

List the purpose for releasing this information: ("at the request of the individual" is all that is required if you do not want to list a specific reason)

Information should be sent to (check and/or provide address):

_____ Marshall University Psychology Clinic _____
One John Marshall Drive _____
Huntington, WV 25755 _____
Attn: _____
Phone: (304) 696-2772 Attn: _____
Confidential Fax: (304) 696-3575 Phone (optional): _____

I understand that I may revoke this authorization at any time by giving written notice 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. Unless revoked earlier, this authorization will remain in effect for one year from the date written on this authorization or until a specified date or event(s) related to the purpose of this disclosure is completed.

(if authorization is for less than one year, provide expiration date or event to be completed that relates to the purpose of this disclosure)

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.)