Marshall University Psychology Clinic
Release of Information/Authorization Form

Client Name _____ Social Security # _____

Date of Birth _____ Phone #: (_____) _____

Address _____
(Street) (City) (State) (Zip Code)

Please mark ("X") the appropriate box(es) & initial after each box checked

I authorize the disclosure of the following information, if such information exists:

☐ _____ client's initials **Medical Information**

☐ _____ client's initials **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)

☐ _____ client's initials **All the Medical, Clinical/Psychological, & Other Information That May Pertain to My Care**

☐ _____ client's initials **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)

_____

Circle Whether Information should be Received (From) and/or Released (To)

(circling BOTH "From" & "To" for MU & for the other agency/person will allow for two-way communication between the parties)

Information should be sent to and/or obtained from:

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

From / To _____
_____
_____
_____
Attn: _____
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.)

_____ _____
Witness (Clinician) Date