DR. LUCILLE KEENAN
Clinical Psychologist
1330 St. Mary's Street • Suite A020 • Raleigh • NC 27605
919 • 604 • 7401

This form when completed and signed by you, authorizes _____ to exchange protected information from your clinical record to **Dr. Lucille Keenan.**

Patient Name: _____Birth Date: _____

I authorize Name/Agency: _____

Address: _____

Phone/Fax: _____

to exchange:

_____Psychological/Psychiatric Diagnostic Evaluation _____Educational Assessment _____School Records

_____Progress Update _____Medical History _____Developmental History

Other (specify):_____

This Information should only be exchanged with:
Name: **Dr. Lucille Keenan**

Address: **1330 St. Mary's Street, Suite A020, Raleigh, NC 27605**

Phone: **919.604.7401**

Purpose of Release: I am requesting this exchange of information for the following reasons:

_____Continuity of Care _____Treatment Planning _____Other _____*At the Request of the Individual

**"at the request of the individual" is all that is required if you do not desire to state a specific purpose.*

This authorization shall remain in effect until __/_____/_____(expiration date) or until (an event that relates to the individual or the purpose of the use or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____

Signature of Patient Date

If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.

_____

Signature of Parent/Guardian Date Relationship