

**Agate Passage Psychological Services, Inc. PS**  
**785 Ericksen Avenue, Suite 117**  
**Bainbridge Island, WA 98110**  
**(206) 842-9949 Fax (360) 697-1079**

**Information Release Authorization Form**

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate, or to obtain specific information from another treating professional. A record will be kept for your review of all requests made on behalf of your treatment.

I authorize my psychologist, **James E. McKeever, Ph.D.** (initial one or both of the following)

\_\_\_\_\_ to release the following information,

or

\_\_\_\_\_ to have the information released to her. (Provide a description of the information that you want disclosed. Your description should be as specific and detailed as possible) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This information should only be released by or to the following:

Name or Function: \_\_\_\_\_

Address: \_\_\_\_\_

I am requesting my psychologist to release/obtain this information for the following reasons and subject to the following limitations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

The Authorization shall remain in effect until (Date) \_\_\_\_\_ or (Function) \_\_\_\_\_

However, I understand that this Authorization does not permit disclosure of my future health care given more than 90 days from the date of this Authorization (unless this is for disclosures to insurance companies). If this Authorization does not contain an expiration date, the Authorization expires in 90 days from the date of my signature.

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

I understand that my psychologist 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 pursuant to this Authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature and relationship of representative, and description of such representative's authority to act for the patient.