Neurobehavior Services, Inc. **Email: Admin@NeurobehaviorServices.com**

Janiece Turnbull, PhD & Associates
Clinical Neuropsychology, Pediatric & Adult
Consultation, Assessment, & Treatment
www.NeurobehaviorServices.com

685 East California Boulevard
Pasadena, CA 91106
Voicemail: 626.577.7744
Fax: 888.220.2463

PERMISSION TO OBTAIN INFORMATION

Patient Name (if Minor, Parent Name):____

I hereby authorize and request Dr. Janiece Turnbull to obtain confidential and professional information, including psychological, academic, psychiatric, medical, written records, treatment progress, etc., as well as opinions resulting from my contacts with them, from:

Name (required): ____

Mailing Address (optional): ____

Email Address (required):____

Phone (required):____

The specific information requested/provided is as follows:

1)

2)

3)

I understand that I have no obligation whatsoever to authorize the disclosure of the requested information and that I may revoke this consent at any time by informing Dr. Turnbull verbally (but must be followed up in writing). The above consent shall expire after a period of 90 days from the date of my signature below.

In consideration of this consent, I hereby release the above parties from any and all liability arising therefrom.

Signature ____ Date ___________________

Signature ____ Date ___________________

Witnessed ____ Date ___________________