

*Janiece Turnbull, PhD & Associates*  
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**PERMISSION TO RELEASE INFORMATION**

Patient Name (if Minor, Parent Name): \_\_\_\_\_

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

Name (required): \_\_\_\_\_

Mailing Address (optional): \_\_\_\_\_

Email Address (required): \_\_\_\_\_

Phone (required): \_\_\_\_\_

The specific information to be 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 \_\_\_\_\_