RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize Dr. Dana Turnbull (address listed above) to release and exchange information to/ with

_____

(name of party who holds your information)

located at_____

(address of party who holds your information)

with telephone/fax numbers:_____

to release the following specified information regarding the treatment dates of_____

("all" or month/year)

on patient_____

(Patient Name)

with date of birth_____.

I request the following information be released/exchanged:

___ Psychiatric evaluation
___ Office Notes
___ Entire Record
___ Other

AND (Please check one of the below)

_____I DO authorize the release of any records that have been obtained by my psychologist from other providers/attorneys/schools/hospitals/etc.

_____I DO NOT authorize the release of any records that have been obtained by my psychologist from other providers/attorneys/schools/hospitals/etc.

I understand these records include drug/alcohol/mental health related information. A photocopy of this authorization should be considered as valid as the original. This consent is subject to revocation by the undersigned. Absent that event, it shall expire six (6) months from the date signed .

_____ _____

Patient signature if 16 or older (date)

_____ _____

Legal guardian signature (if required) Witness Signature