Glen D. Greenberg PhD, ABPP Clinical Neuropsychology

19606 Coastal Highway Unit 101
Rehoboth Beach, Delaware 19971
www.DelawareNeuropsych.com
6Phone 10-566-0501

Authorization to Release Protected Health Information (PHI)

This form authorizes the following individual to release patient records to Dr. Greenberg

Date _____

Name	
Institution or Affiliation	
Street	
City / State / Zip	

Patient name: _____ Date of Birth: ____/____/_____

Effective dates for this authorization: _____ through _____

I, (print your name) _____, is legally authorized to release the following PHI to Dr. Glen Greenberg:

☐ Testing report

☐ Therapy notes

Please fax or email the records to Glen D. Greenberg, PhD, ABPP at:

☐ **Fax** 833-542-2840

☐ **Mailing address**
P.O. Box 594
Westtown, PA 19395

☐ **Email** DelawareNeuropsych@gmail.com

Print your name _____ *Signature* _____

Your relationship to the patient:

☐ Patient ☐ Spouse ☐ Mother ☐ Father ☐ Sibling
☐ Legal Guardian ☐ POA
☐ Other: _____