

19606 Coastal Highway Unit 101
Rehoboth Beach, Delaware 19971
www.DelawareNeuropsych.com

Authorization to Release Protected Health Information (PHI)

*This signed authorization allows us to send patient records to the following individual
Use a separate release form for additional individuals*

Date _____

Patient name _____ Date of birth _____

Effective dates for this authorization: _____ until _____

I, (print your name) _____, authorizes Dr. Greenberg to release to the individual listed below the following patient information from this practice:

- Intake
- Testing report
- Therapy notes

Write the name of the individual you want the information released to:

Name		Profession	
Institution or Affiliation			
Street address			
City		State	Zip
Phone		Fax	

Print your name _____ Signature _____

Your relationship to the patient:

- Patient Spouse Mother Father Sibling
- Legal Guardian Other: _____