Glen D. Greenberg PhD, ABPP

Associates in Neuropsychology and Behavioral Health, PA

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Authorization to Release Protected Health Information (PHI)

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

Provider or other Individual ____

Date: ____________________________

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

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____

I, (print your name) _____________________________, authorizes the above individual to release the following patient information to this practice for purposes of providing patient care:

☐ Diagnostic interview
☐ Testing report
☐ Therapy notes
☐ Other ____

Please fax or email the records to:

Glen D. Greenberg, PhD, ABPP

Fax: 610-566-0502
Email: AssociatesNBH@gmail.com

Thank you!

Authorized Name ____

Signature ____

___ Patient ___ Guardian or POA