40 Huff Avenue
Greensburg, PA 15601
Phone: (724) 836-3960
Fax: (724) 836-2876
E-mail: kps@wvdsl.net
Website: kreinbrookps.com

Dennis W. Kreinbrook, Ph.D.
Licensed Psychologist/Clinical Director
PA License: PS-005992-L

Psychiatrists
Saghir Ahmad, MD
Margaret Boerio, DO
Dale Fruman, MD
Leyla Somen, MD

Physician Assistants
Linda Bizzak, MS, PA-C
Kristopher Durrett, PA-C

Psychiatric Nurses
Debra Coats, CRNP
Donna Falcone, DNP, MS, RN

Licensed Psychologists
Lindsey Groves, Psy.D.
Monica Petroski, Psy.D.
Faisal Roberts, Psy.D.
Peggy Sensué, Ph.D.
Joe Talamo, Ph.D.

Licensed Professional Counselors
Jan Ferguson, BSN, M.Ed.
Leslie Harne, LPC, RPT
Kristi Hixson, MA, LPC
Kelly Lambie, M.S., NCC, LPC
Stephanie O'Mara, MA, LPC
Rachel Taylor, MA, LPC

Licensed Social Workers
Hally Edgar, LCSW
Julianne Kalp, LCSW
David Keys, LCSW

Psychology Residents
Melanie Muller, Psy.D.

Kreinbrook Psychological Services

Authorization for Release of Information

I _____ (Patient, Parent or Legal Guardian), _____ (Birth Date), authorize

X Release from _____
(Person or Organization Making the Disclosure)

Address: _____

Phone Number: _____ Fax Number: _____

X Exchange information ____ Verbally ____ Written ____ Both with _____

X Release to _____
(Person or Organization to which Disclosure is Being Made)

Address: _____

Phone Number: _____ Fax Number: _____

I understand that this information is being requested for the purpose of:

X Continuation of Care ☐ Legal ☐ Insurance ☐ Personal

Description of information to be used or disclosed:

Dates of service: _____

☐ Treatment Records ☐ Laboratory Reports / EKG
☐ Discharge Summary ☐ History / Physical
☐ Consultation -- Date: _____ Physician: _____
☐ Diagnostic Test -- Date: _____ Specify Test: _____
☐ Diagnostic Test -- Date: _____ Specify Test: _____
X Other (please specify): _____

- I understand that the information described above could possibly be re-disclosed by the recipient and no longer protected by the federal privacy regulations. The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that the revocation will not apply if the authorization was related to my obtaining insurance coverage, as the insurer has the right by law to contest a claim or insurance policy. Unless otherwise revoked, this authorization will expire on the following date or event: _____
  If I fail to specify an expiration date or event, this authorization will expire in 90 days.
- I understand that Kreinbrook Psychological Services may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization except in the case of research-related treatment.
- I understand that I can request a copy of this completed authorization form.

_____ _____
(Patient, Parent, Legal Guardian) (Date)

_____ _____
(Witness) (Date)