AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **EVAN D FRANK, MD, PHD, LLC** to release medical information from the records of:

Patient Name:_____ DOB:_____

Covering the period of care (list applicable dates of treatment):_____

Information to be disclosed (circle all that apply):

1. ***Outpatient Treatment Notes*** 2. ***Operative Reports*** 3. ***Lab Results***

Certain information is covered by additional protection and requires specific authorization. To authorize release of the following information, you must initial and date each item below. If the item is not initialed and dated, the information will not be released:

Initial	Date	Info Type	From	To
		Alcohol or Drug Abuse Treatment		
		Mental Health Treatment		
		HIV Status or Treatment		

The information is to be released to:

Name of person or Institution:_____

Address:_____

Phone:_____ Fax:_____

This authorization is effective for the above requested information. This authorization will expire on the date indicated above. You may revoke this authorization at any time by submitting a written request. You have the right to inspect the information you are authorizing to be released. This right as well as others are outlined in our Privacy Practices document. You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment nor will affect your eligibility for benefits.

AUTHORIZED BY:

_____ _____ _____

(Signature of Patient or Authorized Representative) (Printed Name) (date)

_____ _____

(Signature of witness) (date)

In accordance with PA state law, there may be a fee for obtaining copies of records.

Evan D Frank, MD, PhD, LLC Lankenau Hospital, Suite 459 MOB East, 100 Lancaster Ave, Wynnewood, PA 19096
610-642-3800 (phone) 610-642-4982 (fax)