



P.O. Box 224
 Flourtown, PA 19031
 Office: 215-836-0260

AUTHORIZATION and CONSENT TO DISCLOSE INFORMATION:

I hereby authorize Guardian Nurses Healthcare Advocates to obtain the following information from the health records of:

Patient Name: _____ Date of Birth _____ SS# _____

Address: _____ Phone Number: _____

PLEASE CHECK ALL INFORMATION TO BE OBTAINED (Include Dates Where Appropriate)

Date of Service: _____

<input type="checkbox"/> Inpatient Record	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Short Procedure Record	<input type="checkbox"/> Consultation	<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Abstract of Record	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Outpatient Psych Records	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Initial Evaluation
<input type="checkbox"/> Immunization Records	<input type="checkbox"/> School Records	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Other	<input type="checkbox"/> Billing Records	<input type="checkbox"/> Insurance Information

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

INFORMATION TO BE OBTAINED FROM: Please include name and address:

FOR THE PURPOSE OF: HEALTHCARE ADVOCACY AND CARE MANAGEMENT

INFORMATION OBTAINED VIA (please circle) Phone Fax US Mail Other

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Guardian Nurses, Inc. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire on: _____

I understand that authorizing the disclosure of this health information is voluntary. I understand any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

 Signature of Patient or Legal Representative

 Date

 If Signed by Legal Representative, Relationship to Patient

 Signature of Witness