GUARDIAN® NURSES
Healthcare Advocates
P.O. Box 224
Flourtown, PA 19031
Main Number: 888-836-0260

AUTHORIZATION and CONSENT TO DISCLOSE INFORMATION:

I hereby authorize the representatives of Guardian Nurses Healthcare Advocates, on an ongoing basis while providing healthcare advocacy and care services to me, to obtain the following information from the health records of and the clinical staff working with:

Patient Name:_____Date of Birth_____Last 4 SS#_____

Full Address:_____Phone Number:_____

You may seek assistance in completing this form from Guardian Nurses. PLEASE CHECK ALL INFORMATION TO BE OBTAINED. Date of Service: _____

❑	Inpatient Record	❑	Pathology Report	❑	Lab Reports
❑	Emergency Room Record	❑	Operative Report	❑	Radiology Reports
❑	Short Procedure Record	❑	Consultation	❑	Psychiatric Evaluation
❑	Discharge Summary	❑	Abstract of Record	❑	Treatment Plan
❑	Outpatient Psych Records	❑	History & Physical	❑	Initial Evaluation
❑	Immunization Records	❑	School Records	❑	Progress Notes
❑	Other	❑	Billing Records	❑	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 COORDINATION**

INFORMATION OBTAINED VIA (please circle) Phone Fax US Mail Text Message Email

In addition, I authorize Guardian Nurses to communicate with me or my POA by text message. I further understand that those text messages are not secure. Initials_____DATE_____

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