Authorization to Disclose Health Information

Member Information: (Individual whose information will be released)

Name: ______________________________ Date of Birth: ______________
(First, Middle, Last) (Month/Day/Year)

Address: ______________________________
City State Zip Code

Telephone Number: ______________________
(including area code)

Employer Name: ______________________________ Group Plan #: ______________

Employee Name: ______________________________ Social Security Number: ______________

I authorize the use or disclosure of personal and health information by Guardian, as described below:

- ☐ Any and all health information in the possession of Guardian.
- ☐ Claim information regarding treatment for the following condition or injury ______________________________ on or about ______________
- ☐ Health information covering the period of time ______________ to ______________
- ☐ Other (Please specify and include dates) ______________________________

This information may be disclosed to, and used by, the following individuals or organizations:

Name: ______________________________ Relationship______________

Address: ______________________________

City: ______________________________ State: __________ Zip: __________

Name: ______________________________ Relationship______________

Address: ______________________________

City: ______________________________ State: __________ Zip: __________

This information is being disclosed for the following purpose(s):

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I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Guardian at the address below. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to Guardian when the law provides it with the right to contest a claim under my group plan. Unless otherwise revoked, this authorization will expire within twenty four (24) months of the signature date.

I understand that I do not have to sign this authorization and that Guardian may not condition treatment or payment on whether I sign this authorization.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

Print Name: ______________________________ Relationship: ______________

Signature: ______________________________ Date: ______________

Note that no authorization to disclose health information will be processed unless you or your authorized representative have signed this form.

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the member (e.g., Power of Attorney).

Please send this form to:

The Guardian Life Insurance
Company of America
Group Quality
P.O. Box 8020
Appleton, WI 54912-8020