GUARDIAN TELEGUARD
INSTRUCTIONS AND AUTHORIZATION

IMPORTANT INSTRUCTIONS
(For Short Term disability claim filing only)

To expedite your disability claim filing process, please call toll-free at 1-888-262-5670 to initiate your claim as soon as your disability begins. Your claim can be initiated Monday through Friday, between the hours 8:00 am – 8:00 pm (EST). Or, you may file online via our secure website at www.guardiananytime.com. Please be prepared to provide the following information:

1. Your full name, address, phone number and social security number
2. Your employer contact name and phone number
3. Your physician's name, address, phone number and fax number
4. If you have not already done so, please sign the authorization portion of this form and provide a copy to your physician to be retained in your patient file.

Important: Prior to initiating your claim, please inform your physician that a Guardian representative will be contacting their office by phone to obtain medical information concerning your claim. Your assistance in this area may help to expedite your claim.

After your claim has been initiated, for questions regarding ongoing claim status please call 1-800-268-2525, or visit us at www.guardiananytime.com.

AUTHORIZATION – please read and sign/date below.

In order to determine if disability benefits are payable, Guardian requires your authorization for the release of medical information pertaining to your claim. Please authorize the release of this information by signing below and ask your physician(s) to retain a photo-copy of this authorization in your patient file. Please complete any other authorizations that your physician requires to allow release of medical information to Guardian. You should also advise your physician that a Guardian Representative will be calling shortly to obtain the needed information. **Please retain your original authorization in the event that it is needed in the future.**

I authorize my physician and/or medical provider to disclose to Guardian any information regarding my diagnosis, treatment, disability status and medical history.

_____
Employee Name – First, Last Name (please print)

_____ _____
Employee/Patient Signature Date

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
All physical, occupational and rehab requests, consultations and progress notes.
All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
All employment, personnel or wage records.
All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: _____

_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____
(See 45CFR § 164.508(c)(1)(vi))

_____
Name and Relationship of Legally Authorized Representative to Patient
(See 45CFR §164.508(c)(1)(iv))

_____ _____
Witness Signature Date

Another online version:

HIPAA COMPLIANT AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

Name: _____ **Medicare/Medicaid #**_____

D/O/B: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure: **Any medical provider that has treated the undersigned.**

3. The type and amount of information to be used or disclosed is as follows: **ENTIRE RECORD** – **Any and all medical records and other information relative to the undersigned care and treatment.**

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

5. I understand 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. 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: **3 years from date of signature**.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ Dated: _____

Client/ guardian