Guardian

HIPAA Authorization to Use / Disclose Protected Health Information for Marketing

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)

Policy Number: _____ Member ID 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):

_____

_____

I authorize Guardian, its subsidiaries and affiliates to use or disclose protected health information (PHI) about me, limited to name, email, address, phone number, date of birth, health information, and current enrollment (such as dental, vision, or both) for the purpose of receiving marketing communications concerning other insurance products or services to Guardian, its affiliates, or non-affiliates with whom Guardian has entered into joint marketing agreements.

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. I understand that the revocation will not apply to information that has already been released in response to this authorization or to the extent that Guardian already has taken action in reliance on the authorization. Further details may be found in the Guardian HIPAA Notice of Privacy Practices. Unless otherwise revoked, this authorization will expire at the termination of your health plan.

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

☐ I have read the above and authorize the use and disclosure of the protected health information as stated.

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
PO Box 981587
El Paso, TX 79998-1587