



Dear Guardian

PacWest will work with a patient's Guardian to better improve communication and care that we provide to their unique patient population who reside in ALF, AFH, LTC and Independent Living Communities. By partnering with a consistent and reliable provider you can reduce delays in response that can impact patient receiving the services and equipment that they need.

If you are interested in speaking with our staff in how we can partner, please reach out through one of the following ways below.

If you want PacWest to begin management of your patients please fill out Guardian enrollment form along with the authorization of medical records so we may begin the admission process.

Email: [officeadmin@pacwesthc.com](mailto:officeadmin@pacwesthc.com)

Fax: (509) 418-5789

Phone: (360) 880-8193

M-F 8am-5pm PST

Sincerely,  
PacWest Healthcare Team

\*Patient and facility enrollment forms can be printed from our website [pacwesthealthcare.com](http://pacwesthealthcare.com) and returned by either email or fax



Guardian Enrollment Form

Name of Guardian:  Phone #

Patient Name

Name and contact information for facilities which may include ALF, AFH, ILF and LTC facilities\*

Name of person who will assist in filling out patient enrollment packet to include phone #

If you have multiple patients please feel free to send information via secure email or fax in the most convenient format or by utilizing more than one of these forms

	Patient Name	Facility Name	Facility Phone Number	Person who will assist in filling out Patient Enrollment Packet
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Please email form to Email: [officeadmin@pacwesthc.com](mailto:officeadmin@pacwesthc.com) and/or Fax: 509-418-5789**

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\*Please note we do not provide PCP services to individual's who live at in a solitary domicile



Guardian Release of Information Form

**Authorization for Release of Medical Records**

Release To: PacWest Healthcare

Patient Name:

Date of Birth:

Guardian Name:

**\*Please Check Box below for Type of Medical Information you Authorize for Release to PacWest**

All prior available medical records from prior PCP and/or other healthcare entities

I understand that this authorization may be revoked in writing at anytime. I have been informed and understand my right to privacy, security, and confidentiality of medical information. I understand that no information may be released without my expressed written consent or that of my legal representative, or otherwise provided by law. This facility, its employees, officers, and physicians are hereby released, from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Guardian Signature.

Date

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