INTERNATIONAL MEDICAL GROUP

PRIVACY AND CONFIDENTIALITY RELEASE FORM

By completing this form, you are providing your consent to IMG® to discuss your claim activity with the person(s) listed below. Without this release form, IMG cannot discuss your claims activity with anyone other than your physician(s) or provider(s) of service.

I authorize IMG to discuss my claim activity with _____.
This authorization is valid for_____months from the date signed.

I give IMG permission to release any or all of the following information:

(Please select and initial)

☐ _____ All financial and claim information related to medical bills or Claimant's Statement and Authorization.

☐ _____ Provider name, date of service, total charge, total paid and date of payment.

☐ _____ Insurance ID number and/or social security number.

Under no circumstances can IMG release medical information obtained from your physician or provider of service to you or anyone. Your medical information has been disclosed to us from your physician or provider of service and we are prohibited by federal law for further disclosure. Please contact your physician or provider of service for your medical information.

_____ _____
Print Patient Name Insurance ID Number

_____
Signature of the Patient or Insured Person if the patient is a minor child

_____
Date

Please provide your current mailing address:

Street Address	
City	State, Country, Postal Code

Mail or fax to: **Claims Department**
International Medical Group
P.O. Box 88500
Indianapolis, IN 46208-0500
Telephone: 317-655-4500
Fax: 317-655-4505