

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 and is made at the request of the undersigned. | |
| I give IMG permission to release any or all of the following information: (Please select and initial) <input type="checkbox"/> _____ All financial and claim information related to medical bills or Claimant's Statement and Authorization. <input type="checkbox"/> _____ Provider name, date of service, total charge, total paid and date of payment. <input type="checkbox"/> _____ Insurance ID number and/or social security number. If you require copies of the medical information we have obtained from your physician or provider of service, please contact your physician or provider of service for your medical information. | |
| Print Patient Name: _____ | Insurance ID Number: _____ |
| Signature of Insured/Legal Representative: _____ | Date: _____ |

Please provide your current mailing address:

| | |
|-----------------------------------|--------------------------------------|
| Street Address: _____ _____ | |
| City: _____ | State, Country, Postal Code _____ |

For improved user experience, communication, and efficiency, we recommend you submit your claim online via MyIMG. While most IMG products are available for online claims submissions, please continue to use this form for all other products

CLAIMS DEPARTMENT

International Medical Group

P.O. Box 240429, Apple Valley, MN 55124

Telephone: **317.655.4500** Fax: **317.655.4505**

Web: www.imglobal.com/secure-message-center

