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)** ☐ _____ 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. **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

CLAIMS DEPARTMENT
International Medical Group
PO Box 9162
Farmington Hills, MI 48333
Telephone: **317.655.4500**
Fax: **317.655.4505**