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, Inc. Claims, P.O. Box 240429, Apple Valley, MN 55124 USA,
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Fax: **+1.317.655.4505**