

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 _____

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