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 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.

Please Select and Initial:

☐ _____ All financial and claim information related to medical bills or Health Benefit Plan Claim Form or Healthcare Allowance Medical Reimbursement Form.

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

☐ _____ IMG Member ID, NSPID (issued by AmeriCorps), 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 Member Name | Date of Birth | IMG Member ID

_____ _____

Member Signature | Date

Please provide your current mailing address:

_____

Street Address

_____ _____

City | State, Country, Postal Code

Please submit to: AmeriCorps VISTA Claims Department
International Medical Group
P.O. Box 88506
Indianapolis, IN 46208
Fax: 1-855-851-2971
E-mail: vistacare@imglobal.com