# AmeriCorps VISTA

## Privacy and Confidentiality Release Form

POWERED BY IMG

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.

Please answer the following questions.

Submit the completed form to IMG by secure means at:
E-mail*: **VISTAcare@imglobal.com** Fax: **(855) 851-2971**
Postal Mail: **International Medical Group ATTN: AmeriCorps VISTA Claims, P.O. Box 21605, Eagan, MN 55121**
If you have any questions, please call IMG at **(855) 851-2974** or **(317) 833-1711**

### Member Information:

I authorize IMG to discuss my claim activity with:

This authorization is valid for _____ months from the date signed.

| | |
|---|---|
| ❑ | 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.

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|---|---|---|
| Print Member Name: | Date of Birth: __/__/__ (MM/DD/YY) | Member ID: |
| Member Signature: X _____ | | Date of Signature: __/__/__ (MM/DD/YY) |

### Please provide your current mailing address

| | | |
|---|---|---|
| Home Address: | | |
| City: | State/Country: | Postal/Zip Code: |
| If your address has changed, please visit the MyAmeriCorps portal at https://my.americorps.gov to update. | | |

*Notice on Electronic Communication and Privacy: Please submit these documents via secure means, such as encrypted email or by fax. If you choose to send the information via unsecure email, you are solely responsible for any subsequent data breach or data loss caused by your decision. To protect your private information, we recommend you consider using any secure or confidential/encrypted email sending options with your email service provider. You may also consider password protecting your documents and sending the password in a separate email.*

*We are required by the Privacy Act of 1974 (5 U.S.C. 552a) to tell you what personal information we collect and how it will be used: Authorities – This information is requested pursuant to 42 U.S.C. 4955, Support services; 42 U.S.C. 12618, Authorized benefits for Corps members; and 45 CFR § 2556.320 - What benefits may a VISTA receive during VISTA service? Purposes – It is requested to manage and evaluate the health benefits programs offered to VISTA, NCCC, and FEMA Corps Members. Routine Uses – Routine uses of this information may include disclosure to (1) health care providers and insurance companies to provide care and coordinate payment, (2) contractors to assist with providing the health care benefit, and (3) federal, state, or local agencies pursuant to lawfully authorized requests. Effects of Nondisclosure – This request is voluntary, but not providing the information will likely affect your ability to receive your health care benefits.*

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