IPMG
INSURANCE PROGRAM MANAGERS GROUP

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Participant Name:	Address, City, ZIP:	Birth Date:

I hereby authorize my identified health care provider(s) to release and disclose the medical information and other records listed below that may include Protected Health Information about me to IPMG Employee Benefits Services (IPMG), at 225 Smith Road, St. Charles, IL 60174. "Protected Health Information" or "PHI" includes any information that relates to (1) My past, present or future physical or mental health or condition; or (2) Health care I have received or will receive; or (3) Payment for health care I have received or will receive.

Purpose of Disclosure. All such medical information and PHI may be disclosed by verbal/oral, email, or other form of written communication to IPMG and/or individuals working on its behalf for purpose of informing them of my medical condition and treatment, as reasonably requested for workers' compensation purposes, certification and payment of medical expenses, and discharge planning, ongoing case management, wellness service coordination, and other integrated care management services as disclosed to me by IPMG at the time of this Authorization.

The following specific information to be disclosed:

☐ All medical and billing records or any other information maintained by you (including records prepared by others that are in your possession) regarding the above listed Participant;

or only the following:

☐ Health Treatment ☐ Dental Treatment ☐ Vision Treatment
☐ Other _____
☐ Records related to the following treatment: _____
☐ Related to the following time period(s): _____ to _____

I understand that the records to be disclosed pursuant to this Authorization may contain records or information relating to treatment or participation in the following: *Initials*

√ Federally assisted drug or alcohol abuse programs _____
√ HIV Testing or HIV or AIDS Status _____
√ Diagnosis and Treatment of Mental or Psychological Health _____
√ Genetic testing information and/or records _____

I understand that such information is subject to special protections pursuant to state and federal laws. By my initials, I authorize the use or disclosure of such records if they are otherwise included within the scope of this Authorization

I understand that IPMG shall be authorized to use and disclose my PHI in the manner provided under applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), as described in its *Notice of Privacy Rights*. I have the right to revoke this Authorization in writing, except to the extent the provider has taken action in reliance upon this Authorization. I also understand a photocopy or facsimile of this Authorization shall be considered as effective and valid as the original. I understand that I may see and copy the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it. *I understand that this Authorization is voluntary and that I may refuse to sign this Authorization*. My refusal to sign will not affect my ability to seek and receive treatment, payment for submitted claims or maintain other eligibility for any other coverage provided under my employer's employee benefit plan(s).

I understand that my Protected Health Information may also be used or disclosed for purposes of responding to the lawsuit or claim brought by me or involving me. I understand that my PHI may be made available to various parties also involved with or defending such legal action by me or involving me, and that the information, once disclosed, might no longer be subject to certain state or federal privacy protections once released.

With respect to PHI or other information provided for or by my group health plan for health benefit purposes only, this Authorization expires on the earlier of _____, 20__ or the following event:_____
_____, but such expiration will not be effective as to records already released in reliance on the Authorization.

_____ _____
Signature of Participant or Personal Representative Date

Personal Representative Section

If a Personal Representative executes this form, that Personal Representative warrants that he or she has authority to sign this form on the basis of:

☐ Legal Authority (Power of Attorney, etc.) Please attach documentary evidence.
☐ Parent, Guardian or other individual acting *in loco parentis*
☐ Written Designation by the Patient or Participant