AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)

I authorize any licensed doctor, practitioner of healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance company, group policy holder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial or employment status of the participant named below, to provide this information to International Medical Group or any agent or administrator acting on its behalf.

I also authorize International Medical Group to provide my medical records to any licensed doctor or hospital in order to obtain information for treatment.

I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. I understand that the duration of the authorization is for the duration of the claim.

Printed name of Participant	Date
Signature of Participant	

Phone: +1.463.276.5286 | *Email:* ASPEcare@imglobal.com