

# Authorization to Release Information

Return to: IBBP Billing Department  
515-286-4369 fax

*Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the participant's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the participant. This authorization may be revoked by the participant at any time.*

**I hereby authorize:** Iowa Bankers Insurance and Services, Inc., on behalf of the Iowa Bankers Benefit Plan (collectively, "the Plan"), whose principle office is located at 8800 NW 62nd Avenue, PO Box 6210, Johnston, Iowa 50131-6210.

**To disclose from the records of:**

Name:	Last	First	MI	Previous Names	
Birth Date	Social Security		Home Phone	Work Phone	
Address	Street	City		State	Zip

**To disclose to:** \_\_\_\_\_

The following information may be disclosed: \_\_\_\_\_  
(any and all medical information)

For the purpose of: \_\_\_\_\_  
(if requested by the participant simply state "At the request of the Participant")

I understand that this will include information relating to (check and initial if applicable):

\_\_\_ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection

\_\_\_ Behavioral health service/psychiatric care

\_\_\_ Treatment for alcohol and/or drug abuse

If compensation will be received: I understand that the Plan will receive compensation for its use/disclosure of the information released pursuant to this authorization.

\_\_\_\_\_  
patient initials

**Affirmation of Release**

I give the Plan or the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named. I understand that this authorization is valid up to the expiration date stated below and I may refuse to sign this authorization or revoke this authorization at any time by contacting IBIS. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received by IBIS in writing. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

\_\_\_\_\_  
Signature of Participant/ Representative & Relationship if applicable

\_\_\_\_\_  
Date Signed

Expiration Date: \_\_\_\_\_



\*213\*