



Indiana Public Employers' Plan, Inc. Please email to: ipep@ipepclaims.com	Toll free: 1-800-382-8837 Local: 1-765-457-9161 Claims fax: 1-765-868-3310
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Adjuster:

Claim No:

**AUTHORIZATION FOR RELEASE OF  
MEDICAL, MILITARY, EDUCATION AND WAGE INFORMATION**

**To any physician, dentist, hospital, health care practitioner, military authority, education authority, employer or insurance carrier:**

The requested information is needed to accurately evaluate, adjust and pay the patient's insurance claim.

I hereby authorize any health care professional (including health care physicians, medical practitioners or other health care providers, hospitals, medical attendants, nurses, x-ray technicians, or any other person), military authority, education authority, employer or insurance carrier, to furnish to the insurance company named above or its authorized vendors and representatives, wage loss and individually identifiable health information regarding my injuries, payment, treatment rendered, or health care received or provided. I understand that this authorization is voluntary.

I agree that a photocopy or fax of the original authorization shall have the same force and effect as the original.

I understand that my health care records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I may revoke this authorization at any time by notifying the health care professional(s) in writing, but if I do it will not have any affect on any actions taken before receipt of the revocation.

I understand that once disclosed, the information and documentation released may be re-disclosed and may no longer be subject to the HIPAA Privacy Rule.

This disclosure is made at the request of the individual named below for the purposes of evaluation, adjusting and paying an insurance claim.

Unless otherwise required by law, this authorization shall expire upon the final resolution of the insurance claim.

By signing below, the patient acknowledges that he /she has read the fraud statement printed below.

\_\_\_\_\_  
PATIENT OR REP SIGNATURE

\_\_\_\_\_  
PATIENT ADDRESS

\_\_\_\_\_  
PATIENT NAME OR REP (PLEASE PRINT)

\_\_\_\_\_  
CITY, STATE, ZIP

\_\_\_\_\_  
REPRESENTATIVE'S RELATIONSHIP TO PATIENT

\_\_\_\_\_  
PATIENT PHONE NUMBER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SOC SEC NUMBER

\_\_\_\_\_  
DATE OF BIRTH

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.**