

# Work & Travel USA

CIEE Partner:

**Business Travel Club**

Country:

**Poland**

## Privacy, HIPAA and Confidentiality Release Form Summer 2009

By completing this form, you consent to CIEE, CIEE's designated insurance claims management company, your physician's and/or other medical providers to discuss medical and/or insurance issues with CIEE or CIEE's designated insurance claims management company.

You also consent to CIEE that we may notify your emergency contact listed in this application of any situation that CIEE deems to be an emergency. You also consent to CIEE that CIEE may notify your official CIEE Partner from whom you purchased this program of any situation that CIEE deems to be an emergency.

This authorization is valid for two years from the date signed.

I give CIEE permission to release any or all of the following information. (Please initial and select)

Initial:  All financial and claim information related to medical bills or Claimant's Statement and Authorization.

Initial:  Provider name, date of service, total charge, total paid and date of payment.

Initial:  Insurance ID number and/or social security number.

Under no circumstances can CIEE 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.

Print Patient Name:

Signature of the Patient, Adult Parent or Guardian:

Date (DD/MM/YYYY):