Island Group Administration, Inc.

Corporate Offices
3 Toilsome Lane, East Hampton, New York 11937
Phone: (631) 324-2306 or 1-800-926-2306
Fax: (631) 324-7021 or (631) 329-0152

Dear Participant:

Re: HIPAA Regulations

Due to the new HIPAA regulations Island Group Administration, Inc. can only release information to the patients regarding their own benefits. Each covered individual must mail or fax an Authorization For Release of Information Form in order for anyone else to receive information on his or her behalf.

On the reverse side of this letter is an Authorization For Release of Information Form. Please complete this form for you and your dependents and return it to Island Group Administration, Inc. as soon as possible.

Please note it is ***not*** necessary to complete the form for dependent children unless you would like someone other than parents/legal guardians to be given authorization to receive information.

If you have any questions, please do not hesitate to contact your Plan Manager at our office.

Sincerely,

Alan D. Kaplan
President

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AUTHORIZATION FOR RELEASE OF INFORMATION

In cases requiring disclosure of Island Group Administration information to ***someone other than yourself***, the following authorization must be completed and returned to our office at:

Island Group Administration, Inc.
3 Toilsome Lane
East Hampton, NY 11937

*** You may fax your request to: (631) 324-7021**

***PATIENT'S* NAME:** ____

***INSURED'S* IDENTIFICATION NUMBER:** ______________________________

***INSURED'S* EMPLOYER:** ____

****Please note a separate form must be filled out for each patient***

I give Island Group Administration authorization to release information regarding my Island Group Administration records to the ***individual(s) or organization*** listed below. I understand that unless I state otherwise, ***ALL*** information may be discussed or released to authorized individuals.

First & Last Name of ***Individual(s)*** *(please print)*: ______________________________
and/or ***Organization***

____

____

____

How long would you like this information released? *(check one)*:

- ☐ One time-release / Date: ____________________
- ☐ Ongoing release
- ☐ Limited-time release (specify time): from__________ to__________

This signed statement will remain valid for the entire time you have chosen unless you inform us in writing. If you are signing as a Power of Attorney, please attach Power of Attorney documentation.

______________________________ ______________________________

Signature of Patient Date Signature of Authorized Individual(s) Date

March 19, 2009