Attachment 15

FORM #2

**CMS / Medicare**

**CONSENT TO RELEASE of INFORMATION**

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to disclosed, discuss, and/or release, orally or in writing, information related to my worker’s compensation injury and/or settlement to the individual(s) and/or firm(s) listed below.

**Please Check: *Name*/*Address/phone/fax/email***

( ) Claimant’s attorney

( ) Employer’s attorney

( ) Workers’ compensation carrier

( X ) Medicare Set-Aside Consultant TBD

How long can we give out the information? (Check one)

( ) Ongoing, beginning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Month/Date/Year

( ) Limited time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Month/Date/Year Month/Date/Year

( ) One time only

Claimant’s Signature Date

Social Security Number or Health Insurance Claim # Date of Injury

**If your Power of Attorney (POA) or legal representative signs this form for you, a copy of their POA or representation papers must be sent to us with this form.**

Completion and signing of this consent form:

* Authorizes release of information to the person named above upon their request. This means that information disclosed to the above named person may be re-disclosed by them and may no longer be protected by law.
* Allows release of Medicare claims and other information related to your injury/illness.
* Is for release of information purposes only and does not affect benefits you are entitled to under the Medicare Program.

You have the right to revoke your authorization at any time in writing, except to the extent that CMS has already acted based on your permission. To revoke, send a written request to the address listed below:

**Medicare Secondary Payer Contractor**

**Post Office Box 33828, Detroit, MI 48232-5828**

END OF FORM #2