

**Authorization for Use and Disclosure of Protected Health Information
Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

Re: Claimant/Applicant :
Social Security No. :

Purpose: This will authorize the following person(s)/entity to represent the interest of the above claimant in his/her Personal Injury/Liability claim and its possible interaction with Medicare/Medicaid benefits. This request is for use or disclosure of required information in compliance by the beneficiary and his/her Liability carrier with the Medicare Secondary Payer Act.

Person(s)/Entity Authorized to Receive and Use Information:

**PMSI Settlement Solutionssm
Post Office Box 31646
Tampa, FL 33631
(813) 612-5500, Phone
(813) 612-5511, Fax**

I understand that the information described below may be redisclosed by the person or group that I hereby give CMS, its agents and/or contractors, permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors, all liability arising from the disclosure of my health information pursuant to this agreement.

Information to be Disclosed:

1. Lien information and confirming medical records regarding any conditional payments made by Medicare/Medicaid relating to the injury or negligence charges for the period beginning with the date of incident.
2. Authorization to obtain written and/or verbal approval from CMS/Medicare for recommended Medicare set-aside allocation, Medicare lien resolution and any other matter necessary to comply with the Medicare Secondary Payer Act and its interaction with Personal Injury/Liability claims, including registration on mymedicare.gov.

Right to Revoke: I understand that I may inspect or request copies of any information disclosed by this authorization if CMS, its agents and/or contractors, initiated this request for disclosure. I understand that I may revoke this authorization by notifying CMS through its contractor representatives, in writing, knowing that previously disclosed information would not be subject to my revocation request. I understand refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

This authorization cancels all previous authorizations in this matter with the exception of the claimant's individual attorney and only authorizes the release of information to a representative of PMSI Settlement Solutionssm. This consent is for my current Personal Injury/Liability claim and is on an ongoing basis. An additional consent to release form will not be necessary unless or until I revoke this authorization (which must be in writing).

Claimant/Individual

Attorney for Claimant, if Represented

Consent Date

Consent Date