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 Workers' Compensation 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 Workers' Compensation carrier with the Medicare Secondary Payer Act.

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

PMSI Settlement Solutions^sm
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, from 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 Workers' Compensation 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 Solutions^sm. This consent is for my current Workers' Compensation 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**

(Revised 06/09)