HUMMEL CONSULTATION SERVICES

CHRISTINE L. HUMMEL, ESQ.
President
christine@hummelcs.com

JOSEPH A. HUMMEL, IV
Vice President of Operations
joseph@hummelcs.com

POST OFFICE BOX 420
NEWMARKET, NEW HAMPSHIRE 03857

501 KENT PLACE
NEWMARKET, NEW HAMPSHIRE 03857

Telephone: (603) 758-1410
Facsimile: (978) 338-8116

Please use the Kent Place address for delivery services only.

http://www.hummelcs.com

CONSENT TO RELEASE

I, _____ (print your name exactly as shown on your Medicare card) hereby authorize someone other than my attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to my liability insurance (including self-insurance), no-fault insurance or workers' compensation claim.

I, _____ (print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Insurance Company ( ) Workers' Compensation Carrier (X) Other: Third Party Administrator

Name of entity: Hummel Consultation Services

Contact for above entity:

Address: Post Office Box 420
Newmarket, New Hampshire 03857

Telephone: (603) 758-1410

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign and date below):

☐ One Year ☐ Two Years ☐ Other _____
(Provide a specific period of time)

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: _____ Date Signed: _____

Note: If the Beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the Beneficiary's behalf.

Medicare Health Insurance Claim Number or Medicare Beneficiary Identifier: _____

Date of Injury/Illness: _____