CONSENT TO RELEASE

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.

Claimant: _____

Date(s) of Injury/Illness: _____

Date of Birth: _____

SSN, HICN, or MBI: _____

I, _____, hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and its contractors to disclose, discuss, and release, orally or in writing, information related to my workers' compensation injury and settlement to the individual(s) and firm(s) listed below. This consent is for my current workers' compensation claim and is on an ongoing basis. An additional consent to release will not be necessary unless and until I revoke this consent (which must be in writing).

Further, I have had the Workers' Compensation Medicare Set-Aside Arrangement need and process explained to me, and I approve of the contents of the submission.

Claimant's Initials: _____

Release to: MSA Vendor:

Hummel Consultation Services
Post Office Box 420
Newmarket, NH 03857
Phone: 603-758-1410
Fax: 978-338-8116

_____ _____

Signature of Claimant Date Signed

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

Completion and signing of this consent form:

- Authorizes release of information to the firm named above upon their request. This means that information disclosed to the above-named firm 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 below:

Medicare Secondary Payer Contractor
Post Office Box 138832
Oklahoma City, Oklahoma 73113