

**CONSENT TO RELEASE**

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       Other \_\_\_\_\_  
(Explain)

Name of entity: \_\_\_\_\_

Contact for above entity: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

**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)

I understand and I may revoke this "consent to release information" at any time, in writing.

**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. Please visit [www.msprc.info](http://www.msprc.info) for further instructions.

Medicare Health Insurance Claim Number (The number on your Medicare card.): \_\_\_\_\_

Date of Injury/Illness: \_\_\_\_\_