Consent To Release

I , _____ hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date(s) of injury/illness to the firm listed below.

I also authorize the CMS, its agents and/or contractors to disclose, discuss, and/or release, orally or in writing, information related to my injury/illness and/or settlement to the below listed law firm for the purposes of approval of the proposed Medicare Set Aside arrangement and notice of any conditional payments that CMS may claim.

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 MSA Provider

Name of entity: **Marker 28**
Address: **444 Broadway, Suite 306**
Saratoga Springs, NY 12866
Telephone: **(833) 288-2828**

I understand that the information used or disclosed may be subject to re-disclosure by Marker 28 receiving it, and would then no longer be protected by federal privacy regulations. The recipient of this information is prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements. In compliance with the Health Insurance Portability and Accountability Act (HIPAA), I may inspect or copy any information to be used and/or disclosed under this authorization. I may revoke this authorization by notifying Marker 28 in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This consent is for my workers' compensation and/or liability claim for the date(s) of injury specified below. An additional consent to release form will not be necessary until I revoke this authorization (which must be in writing).

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE

Beneficiary Signature: _____ Date signed: _____

Guardian's signature (if applicable) _____

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 for further instructions.

Medicare HICN (number on your Medicare card or SSN): _____
Medicare effective date (on your Medicare card):_____
Date of Birth: _____
Date(s) of Injury/Illness: _____