AUTHORIZATION AND CONSENT TO RELEASE,
USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Re: Claimant: **Date of Birth:**
Social Security Number: **Date of Injury:**

I, the above-referenced claimant, do hereby voluntarily authorize the Social Security Administration (SSA), the Department of Treasury (DOT) and the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors, including all Medicare Advantage Plans and Medicare Prescription Drug Plans, to release, upon request, a copy of the BPQY report and any and all information related to the issues listed below. In addition, I authorize the entities listed above and below to discuss and resolve any conditional payment claims related to the above listed date of injury.

- X My injury/illness and related medical records
- X Social Security Number
- X Status of application for benefits
- X Date of Medicare entitlement
- X Information about Social Security Disability and Medicare claim/coverage from date of entitlement to present
- X The settlement of my claim
- X Date applied for disability benefits
- X Date benefits began
- X Basis for entitlement to benefits
- X Payment of medical expenses and/or prescription medications made on my behalf
- X Information concerning any and all Medicare conditional payment claims including but not limited to requests 1) to resolve such claims and 2) for reductions and/or waivers of the amount due

to and with the individuals and entities (and their employees) named/described below:

Carr Allison, P.C.,
Attorneys at Law
100 Vestavia Parkway
Birmingham, AL 35216
(205) 822-2006

This authorization for release of information is effective:
X Ongoing, beginning _____ Limited time _____ through _____

Right to Revoke: I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke this authorization, I will contact Carr, Allison at (205) 822-2006.

Completion and signing of this consent form:

- Authorizes the entities named above to release and disclose any and all Social Security and/or Medicare information, claims, records and/or documents pertaining to myself and any other information deemed necessary or desirable to determine my public benefits status and/or the Medicare Set-aside arrangement related to my injury/illness to the entities named above upon their request. This means that information and medical records disclosed to Carr Allison may be re-disclosed by them. As a result of such disclosure, I understand that my medical history and records may no longer be protected by law.
- Authorizes the entities named above to release information and documentation to structured settlement brokers, pharmacists, account custodians, the SSA and/or CMS to determine my public benefits status and/or my Medicare Set-aside arrangement.
- Authorizes this release to be used for information purposes only and does not affect the benefits I am entitled to under the Social Security and/or Medicare program.
- Authorizes the entities named above to discuss verbally and in writing any and all issues concerning Medicare conditional payment claims, including payments made by a Medicare Advantage Plan and/or Medicare Prescription Drug plan, and Medicaid claims which may be asserted in connection with the above listed date of injury and to resolve the same.

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

I am the individual to whom the information/records applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information or documentation from the SSA and/or Medicare, I could be punished by a fine or imprisonment or both.

_____ _____
Claimant Name Date Signed

Please list the Medicare Card Number and enclose a copy of your card :_____