

CONSENT TO RELEASE

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your 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 Other MSA vendor/firm
(Explain)

Name of entity: Hedrick Gardner Kincheloe & Garofalo, LLP
Contact for above entity: Shannon Metcalf
Address: 4201 Congress Street, Suite 300, Charlotte, North Carolina 28209
Telephone: 704-319-5454

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.

Beneficiary Initials: _____

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 that 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 <https://go.cms.gov/cobro> for further instructions.

Medicare ID (The number on your Medicare card.): _____

Date of Injury/Illness: _____