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.

- 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 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: _____

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 Initials _____