MSPRC

Medicare Secondary Payer Recovery Contract

CMS CENTERS for MEDICARE & MEDICAID SERVICES

CONSENT TO RELEASE FORM

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 to the individual(s) and/or firm(s) listed below:
PLEASE CHECK:

☐ Claimant's attorney _____
(Name and/or firm)

☐ Insurance carrier _____
(Name and/or company)

☐ Other _____ _____
(Explain) (Name and/or firm)

How long can we give out the information? **(Check one Block)**

☐ Ongoing, beginning _____
Month/Date/Year

☐ Limited time _____ through _____
Month/Date/Year Month/Date/Year

☐ One time only

_____ _____
Claimant's Signature Date Signed

_____ _____
Date of Injury Medicare Number

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

Completion and signing of this consent form:

- Authorizes release of information to the person named above upon their request. This means that information disclosed to the above named person may be re-disclosed by them and may no longer be protected by law.
- Allows release of Medicare claims and other information related to your injury/illness.
- Is for release of information purposes only and does not affect benefits you are entitled to under the Medicare Program.

You have the right to revoke your authorization at any time in writing, except to the extent that CMS has already acted based on your permission. To revoke, send a written request to the address below.

Medicare Secondary Payer Contractor
PO Box 33828, Detroit MI 48232-3828