MEDICARE AUTHORIZATION FORM

****ALL SECTIONS REQUIRED****

SECTION A: BENEFICIARY INFORMATION

Enter beneficiary name as it appears on Medicare card.

First Name:	Middle Name:	Last Name:
Date of Birth *(mm/dd/yyyy)*	Medicare Identification Number:	

Address:

City:	State:	Zip code:

SECTION B: RECORD DETAILS DEFINITION

Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** option:
- ☐ Release **all** records to date
- ☐ Release records in timeframe from start date _____ to end date: _____

NY residents only:
- ☐ Include all records
- ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Indicate whether authorization release is for a one-time disclosure, or Identify a future date or event when the authorization will expire.

Select **one** option:
- ☐ One-time disclosure
- ☐ Expiration upon specified date _____
- ☐ Expiration upon specified event _____

SECTION C: RELEASE INFORMATION TO

Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

Release claim records to beneficiary at mailing address above.

Organization/Individual 1 Name — Recipient 1 Email Address

RECORDS DEPOSITION SERVICE, INC. INFO@RECDEP.COM

Recipient 1 Mailing Address:

PO BOX 5054, SOUTHFIELD, MI, 48086-5054, P: 248-357-3330

SECTION D: PURPOSE FOR REQUEST

This section helps Medicare understand the reason or intent for use for this record request.

At the request of the individual	▪ Litigation

SECTION E: AUTHORIZATION AGREEMENT

I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

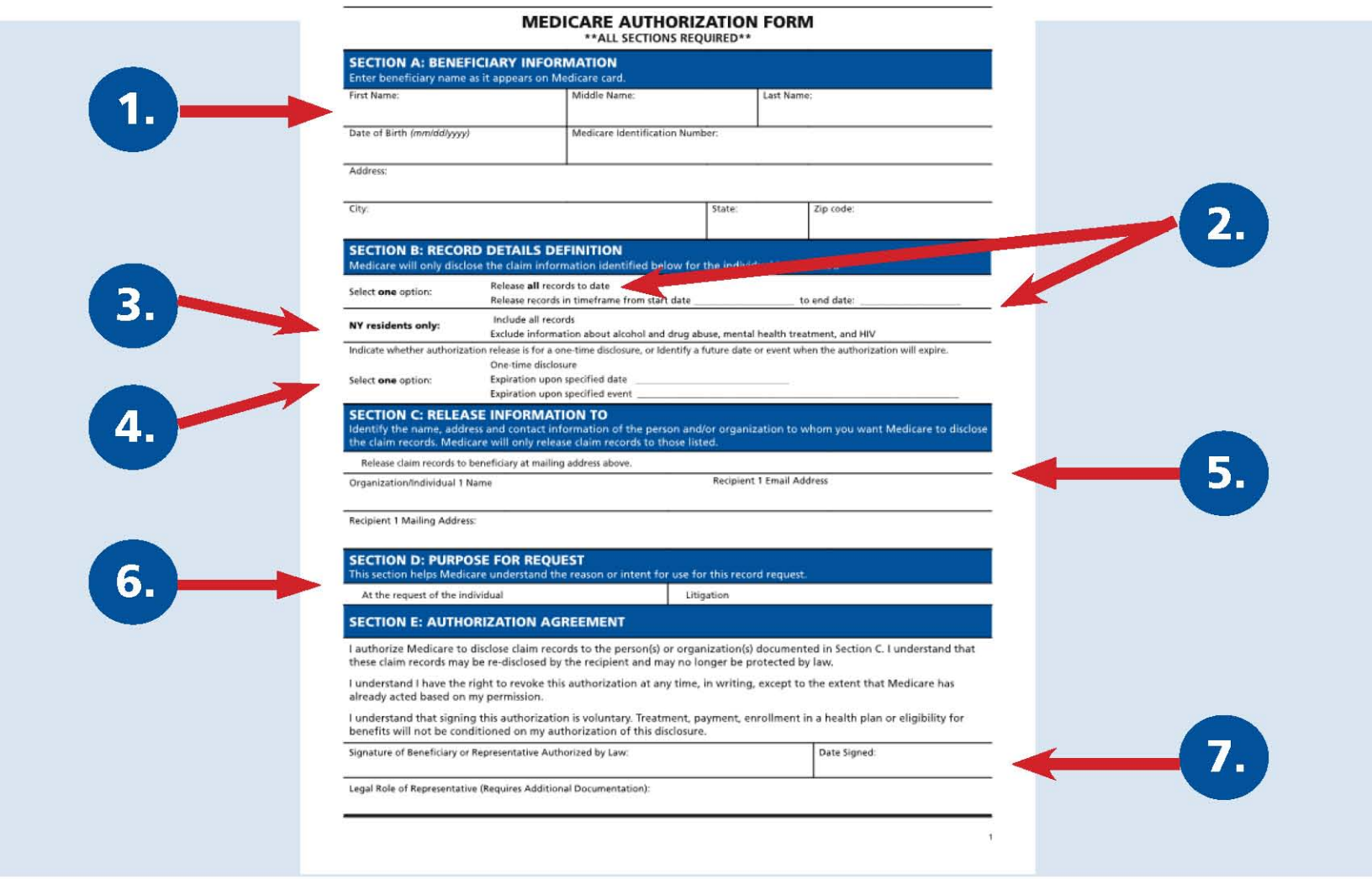
I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.

Signature of Beneficiary or Representative Authorized by Law:	Date Signed:

Legal Role of Representative (Requires Additional Documentation):

Reset All Check Fields



1. BENEFICIARY INFORMATION

Add beneficiary name and ID number as printed on Medicare identification card, date of birth, and address.

2. RECORD TIMEFRAME

Indicate date range of records to release, or select "release all records."

3. NY RESIDENTS: EXCLUSIONS OPT-IN

(NY residents only) Specify whether to exclude records related to alcohol and drug abuse, mental health treatment, and HIV.

4. SELECT EXPIRATION DATE OR EVENT

Indicate date or event information release authorization will expire, if you are not requesting a one-time disclosure.

5. SPECIFY ORGANIZATION TO RELEASE TO

Specify individual(s) to whom records should be released. First name, last name, and address are required. Additional contact information provided will be used only to follow up on questions related to your application submission.

6. SELECT REASON FOR REQUEST

Select purpose for record release request to help Medicare understand how records will be used.

7. BENEFICIARY SIGNATURE

Signature and date by beneficiary or authorized representative in acceptance of HIPAA clauses required to release information. If form not signed by beneficiary, attach notarized Power of Attorney (living individual), or Letters Testamentary and/ or Letters of Administration from the court (deceased individual).