MODEL LANGUAGE

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 AGENT FOR ATTORNEY
(Explain)

Name of entity: RECORDS DEPOSITION SERVICE, INC.

Contact for above entity: _____

Address: PO BOX 5054

Address Line 2: _____

City/State/ZIP: SOUTHFIELD / MICHIGAN / 48086-5054

Telephone: 248-357-3330

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: _____