CONSENT TO RELEASE INFORMATION

Beneficiary: ______________________________
HIC / SS#: ______________________________
Date of Birth: ______________________________
Date(s) of Injury: ______________________________

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from your personal files without your express written permission. Disclosure of your personal records to an attorney or other representative who is acting on your behalf is prohibited without your consent. Your signing of this document authorizes the release of your personal records as described herein.

Medicare and Medicaid Release I hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and contractors, and any State agency providing medical assistance under the Medicaid program, to disclose, discuss and release, orally or in writing, information and records, including but not limited to: my Medicare claim or coverage; my Medicare or Medicaid eligibility, basis, and dates of eligibility; my medical records; and any Medicaid lien, Medicare conditional payment and Medicare set-aside proposal, related to my workers' compensation injury and the settlement thereof; to employees and agents of Protocols.

Social Security Release I hereby authorize the Social Security Administration (SSA) to disclose, discuss and release, orally or in writing, information and records about me, including but not limited to: my Social Security number; identifying information, date and place of birth, and parents' names; my monthly Social Security benefit amount and MPE; monthly Supplemental Security Income payment amount; and information about benefits or payments that I receive or have received; to employees and agents of Protocols.

Access to Confidential Health Information By signing this Consent to Release Information, it is my intent to grant employees and agents of Protocols, the authority to access, receive, review, analyze and disclose, as necessary, any and all records that contain or may contain "Protected Health Care Information" as that term is defined by the Health Insurance Portability and Accountability Act and the rules and regulations promulgated thereunder (collectively known as "HIPAA"). The undersigned further intends that employees and agents of Protocols, be treated as a "Personal Representative" as that term is used in HIPAA and that my medical and health care providers, CMS, SSA, and any other government agency or entity disclose to employees and agents of Protocols, such Protected Health Care Information consistent with the authority granted herein. This authorization shall be effective immediately. This authorization is intended to comply with HIPAA and all other federal, state and local laws, regulations, statutes, and codes related to privacy and the release of medical and health care information.

Effect and Revocation of Release This consent is for my workers compensation, insurance or tort claim and expires (3) three years from the date of signature. An additional consent to release information will not be necessary unless or until I revoke this authorization. I may revoke this authorization at anytime by sending written notice to employees and agents of Protocols, except to the extent that any entity described above has already acted upon the authorization. The granting of this authorization may cause information once protected to no longer be protected by law. A copy and or facsimile of this authorization shall be as valid as the original.

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Signature

Dated:________________________
Mailing Address and Phone:

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