CONSENT TO RELEASE FORM

The Privacy Act of 1974 (Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

Claimant: _____

Date(s) of Injury/Illness: _____

Date of Birth: _____

SSN or HICN: _____

I, _____, hereby authorize and give my consent to the Centers for Medicare & Medicaid Services (CMS), the Medicare Secondary Payer Recovery Contractor (MSPRC), and their agents and/or contractors to disclose, discuss, and/or release, orally or in writing, upon request, information related to my injury/illness and/or settlement to the MSA Vendor named below. My consent includes the submission and negotiation of any Medicare Set Aside (MSA) Proposal and submissions of Reconsideration requests for MSA Proposals by the MSA Vendor. My consent further includes any and all information related to any claims CMS may have under the Medicare Secondary Payer Program and all other statutory and regulatory liens/conditional payment searches to be released to the MSA Vendor. My consent also allows the MSA Vendor to obtain, negotiate and/or appeal any and all Medicare liens/conditional payment searches, including, but not limited to, tentative or final liens and their appeals, related to my injury/illness and/or settlement. A facsimile copy of this document shall be as effective as the original.

Release to: MSA Vendor:

Hummel Consultation Services
Post Office Box 180
Portsmouth, NH 03802-0180
Phone: 603-758-1410
Fax: 603-758-1411

This information may be given out for (check only one):

☐ Ongoing, beginning _____.
(MM/DD/YY)

☐ Limited time _____ through _____.
(MM/DD/YY) (MM/DD/YY)

☐ One time only.

_____ _____
Signature of Claimant Date Signed

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

Completion and signing of this consent form:

- Authorizes release of information to the firm named above upon their request. This means that information disclosed to the above-named firm 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
Post Office Box 138832
Oklahoma City, Oklahoma 73113