Appendix I-4

Medicare Consent to Release

MEDICARE CONSENT TO RELEASE

A. PROGRAM PARTICIPANT'S INFORMATION

1. Name	Last		First	Middle Initial
2. Date of Birth	____/____/____ (MM/DD/YYYY)	**3. Social Security Number**	| | | | | - | | | | - | | | | | | | |	
4. Date of Injury	____/____/____ (MM/DD/YYYY)	**5. Medicare Health Insurance claim Number**		

B. INFORMATION FOR PROGRAM PARTICIPANT'S COUNSEL

6. Does the Program Participant have Legal Counsel?	☐ Yes ☐ No	If Yes, complete Item 7. If No, skip to Section C	
7. Legal Counsel's Name	Last	First	Middle Initial

C. CONSENT TO RELEASE

I, the above-identified Program Participant, 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.

I, the above-identified Program Participant, hereby authorize the CMS to release my information for ( ) 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.

Name of Entity	Contact for Entity	Address	Telephone	Insurance Carrier, Workers' Compensation Carrier, or Other

D. SIGNATURE OF PROGRAM PARTICIPANT

Signature			**Date**	____/____/____ (MM/DD/YYYY)
Printed Name	First	Middle Initial	Last	