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**Consent To Release**

I, \_\_\_\_\_ (print your name exactly as shown on your Medicare card or SSN if not eligible for Medicare) hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date(s) of injury/illness to the firm listed below. This firm does not represent me.

I also authorize the CMS, its agents and/or contractors to disclose, discuss, and/or release, orally or in writing, information related to my injury/illness and/or settlement to the below listed law firm for the purposes of approval of the proposed Medicare Set Aside arrangement and notice of any conditional payments that CMS may claim.

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 **MSA Provider**

Name of entity:                                **Law Offices of Beverly Manley & Associates, PC.**  
Contact for above entity:                **Beverly Manley**  
Address:                                        **P. O. Box 450534**  
    **Atlanta, GA 31145-0534**  
Telephone:                                    **770-493-4167 or 888-908-6629**

This letter will hereby authorize a representative of The Law Offices of Beverly Manley & Associates, P.C. to obtain relevant medical information concerning my liability injury related medical care from my treating providers. The disclosure of this information is for the limited purpose of recommendation and pursuit of CMS approval of a Medicare Set Aside allocation. I understand that the information used or disclosed may be subject to re-disclosure by the law firm receiving it, and would then no longer be protected by federal privacy regulations. The recipient of this information is prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements. In compliance with the Health Insurance Portability and Accountability Act (HIPAA), I may inspect or copy any information to be used and/or disclosed under this authorization. I may revoke this authorization by notifying The Law Offices of Beverly Manley & Associates, P.C. in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This consent is for my liability and/or workers' compensation claim for the date(s) of injury specified below and is for a period of two years from date of this form. An additional consent to release form will not be necessary until I revoke this authorization (which must be in writing).

**MEDICARE BENEFICIARY INFORMATION AND SIGNATURE**

Beneficiary Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

Guardian's signature (if applicable) \_\_\_\_\_

Main Office Mailing Address  
P.O. Box 450534  
Atlanta, GA 31145-0534  
Phone: 770-493-4167  
Fax: 770-934-2021

Main Office Street Address  
2119 Vista Dale Court  
Tucker, GA 30084  
<http://www.bmanlcyma.com>

California Office:  
26741 Portola Parkway  
Ste 1E-624  
Foothill Ranch, CA 92610  
949-307-5211

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 [www.msprc.info](http://www.msprc.info) for further instructions.

Medicare HICN (number on your Medicare card or SSN): \_\_\_\_\_

Date(s) of Injury/Illness: \_\_\_\_\_

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