

CONSENT FORM

RE: Claimant:  
File No:  
Date of Injury:

Dear Ms. Manley:

This is to advise that the undersigned attorney represents the above claimant in his/her liability claim. 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. The disclosure of this information is for the limited purpose of recommendation and pursuit of CMS approval a Medicare Set Aside allocation.

I hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to disclose, discuss, and/or release, orally or in writing, information related to my liability injury and/or settlement to the Law Offices of Beverly Manley & Associates, P.C. for the purposes of approval of the proposed Medicare Set Aside arrangement. The Centers for Medicare & Medicaid Services, Medicare, the Social Security Administration, and the Department of Community Health may also disclose information regarding my SSDI and SSI entitlement status and Medicare/ Medicaid paid claims data for the purposes of compromise, waiver, or repayment of any overpayment by Medicare/Medicaid.

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. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. This consent is for my current workers' compensation claim and is on an ongoing basis. An additional consent to release form will not be necessary unless or until I revoke this authorization (which must be in writing).

\_\_\_\_\_  
Claimant

\_\_\_\_\_  
Attorney for Claimant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Or, if applicable Custodian

\_\_\_\_\_  
Signature of Guardian