MSA MEDICARE SET - ASIDE SPECIALISTS, Inc.

PO Box 1487 • Oldsmar, FL 34677
T:(866) 897-4MSA • F:(813) 891-1920
www.MSAspecialists.com

Consent to Release

I , _____ (print name exactly as shown on Medicare card) 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:

Check only one of the following to indicate who may receive information and then print the requested information: (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 Specialists, Inc.

Name of entity: **MSA Specialists, Inc.**
Contact for above **Fran Provenzano**
Address: **PO Box 1487**
Oldsmar, FL 34677
Telephone: **(866) 897-4672**

Check one of the following to indicate how long CMS may release your information (The period you check will run from when you sign and date below.):

☒ One Year ☐ Two Years ☐ Other _____

I understand that I may revoke this "consent to release information" at any time, in writing.

Medicare beneficiary information and signature:

Beneficiary Signature: _____

Date signed: _____

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 for further instructions.

Medicare Health Insurance claim number (number on Medicare card):_____

Date of injury/illness: _____