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.

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 worker's compensation injury and/or settlement to the individual(s) and/or firm(s) listed below. 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).

PLEASE CHECK:

☐ Claimant's Attorney _____

☐ Employer's Attorney _____

☐ Workers' Compensation Carrier _____

☑ Other CMCM, LLC
344 Grove Street, #51
Jersey City, NJ 07302

How long can we give out the information? **(Check one Block)**

☐ Ongoing, Beginning _____
Month/Date/Year

☐ Limited Time _____ through _____
Month/Date/Year Month/Date/Year

☐ One Time Only _____

_____ _____
Claimant's Signature Date Signed

_____ _____
Date of Injury Social Security No.

_____
Health Insurance Claim Number

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

Completion and signing of this consent form:

- Authorizes release of information to the person named above upon their request. This means that information disclosed to the above named person 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 already has acted based on your permission. To revoke, send a written request to the address below.

Comprehensive Medical Case Management
344 Grove Street, #51
Jersey City, New Jersey 07302