CONSENT TO RELEASE

I , _____(print your name exactly as shown on your Medicare card) hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors, including MyMedicare.gov, all treating physicians, health care providers, and pharmacies, 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 (**X**) Other: Medicare Vendor

Name of entity: **Blackburn Group, Inc.**
Contact for above entity: **And its representatives including but not limited to Robert J. Blackburn and Kathryn T. Blackburn**
Address: **P.O. Box 142, Penfield, NY 14526**
Telephone: **585-586-4530**

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 (**X**) 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.

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.cms.gov for further instructions.

Medicare Health Insurance Card Number: _____

Date of Injury/Illness: _____

Medicare - Data Collections
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