CMS Case Control Number: ___________________________

CONSENT TO RELEASE

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 , _______________________________(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 disclose, discuss and release, orally or in writing, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below. This consent is for my current workers' compensation claim and is on an ongoing basis. An additional consent to release will not be necessary unless and until I revoke this consent (which must be in writing). Further, I have had the Workers' Compensation Medicare Set-Aside Arrangement need and process explained to me, and I approve of the contents of the submission. Beneficiary Initials: _________

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)

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
P.O. Box 138897 Oklahoma City,
OK 73113-8897