

Authorization for Use and Disclosure of Protected Health Information
Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

RE: Claimant/Applicant:
Social Security No:

Purpose: This will authorize the following person(s)/entity to represent the interest of the above claimant in his/her claim for Workers' Compensation and its possible interaction with Medical/Medicaid benefits. This request is for use or disclosure of required information in compliance by the beneficiary and his/her Workers' Compensation carrier/self-insured with the Medicare Secondary Payor Act.

Person(s)/Entity Authorized to Receive and Use Information:

Set Aside Specialists, LLC
PO Box 523
Statesville, NC 28687

I understand that the information described above may be redisclosed by the person or group that I hereby give the Agency and its contract representatives permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release the Agency for Health Care Administration, its workforce members and its contract representatives from all liability arising from the disclosure of my health information pursuant to this agreement.

Information to be Disclosed:

1. Lien information and confirming medical records regarding any conditional payments made by Medicare/Medicaid relating to the injury or negligence charges for the period beginning with the date of incident.
2. Authorization to obtain written and/or verbal approval from CMS/Medicare for recommended Medicare set-aside allocation, Medicare lien resolution and any other matter necessary to comply with the Medicare Secondary Payor Act and its interaction with Workers' Compensation.

Right to Revoke: I understand that I may inspect or request copies of any information disclosed by this authorization if the Agency or its contract representatives initiated this request for disclosure. I understand that I may revoke this authorization by notifying the Agency through its contractor representatives, in writing, knowing that previously disclosed information would not be subject to my revocation request.

I understand refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

This authorization cancels all previous authorizations in this matter with the exception of the claimant's individual attorney and only authorizes the release of information to a representative of Set Aside Specialists. This authorization will expire (2) years from the date below.

Claimant/Individual

Attorney for Claimant, if Represented

Date

Date

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). This authorization will expire (2) years from the date below.

PLEASE CHECK:

Claimant's Attorney: _____

Employer's Attorney: _____

Workers' Compensation Carrier _____

Other: Set Aside Specialists, LLC
PO Box 523
Statesville, NC 28687

Claimant Signature

Date Signed

Date of Injury

Social Security Number or Health Insurance Claim Number