****ALL SECTIONS REQUIRED**

Medicare Authorization Form

Section A: Beneficiary Information		
Name (As it appears on Medicare card):		
Date of Birth:	Medicare ID Number:	
Address:		
City:	State:	ZIP Code:

Section B: Record Time Frame Definition

Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** item: ☐ Release **all** records OR ☐ Timeframe of claim records from start date _____ to end date: _____

NY RESIDENTS MUST ALSO SELECT: ☐ Release **all** records OR ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Identify a future date or event when the authorization will expire (one time disclosure if no date or event provided).

☐ Specified Date _____ OR ☐ Event _____

Section C: Release Information To

Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

1. Organization/Individual Name and Contact: RECORDS DEPOSITION SERVICE, INC.

Organization/Individual Mailing Address:
PO BOX 5054, SOUTHFIELD, MI 48086-5054 F (248) 357-3337 E requests@recdep.com

2. Organization/Individual Name and Contact:

Organization/Individual Mailing Address:

Section D: Purpose for Request

This section helps Medicare understand the reason or intent for use for this record request.

☐ At the request of the individual	☒ Litigation

Section E: Authorization Agreement

I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

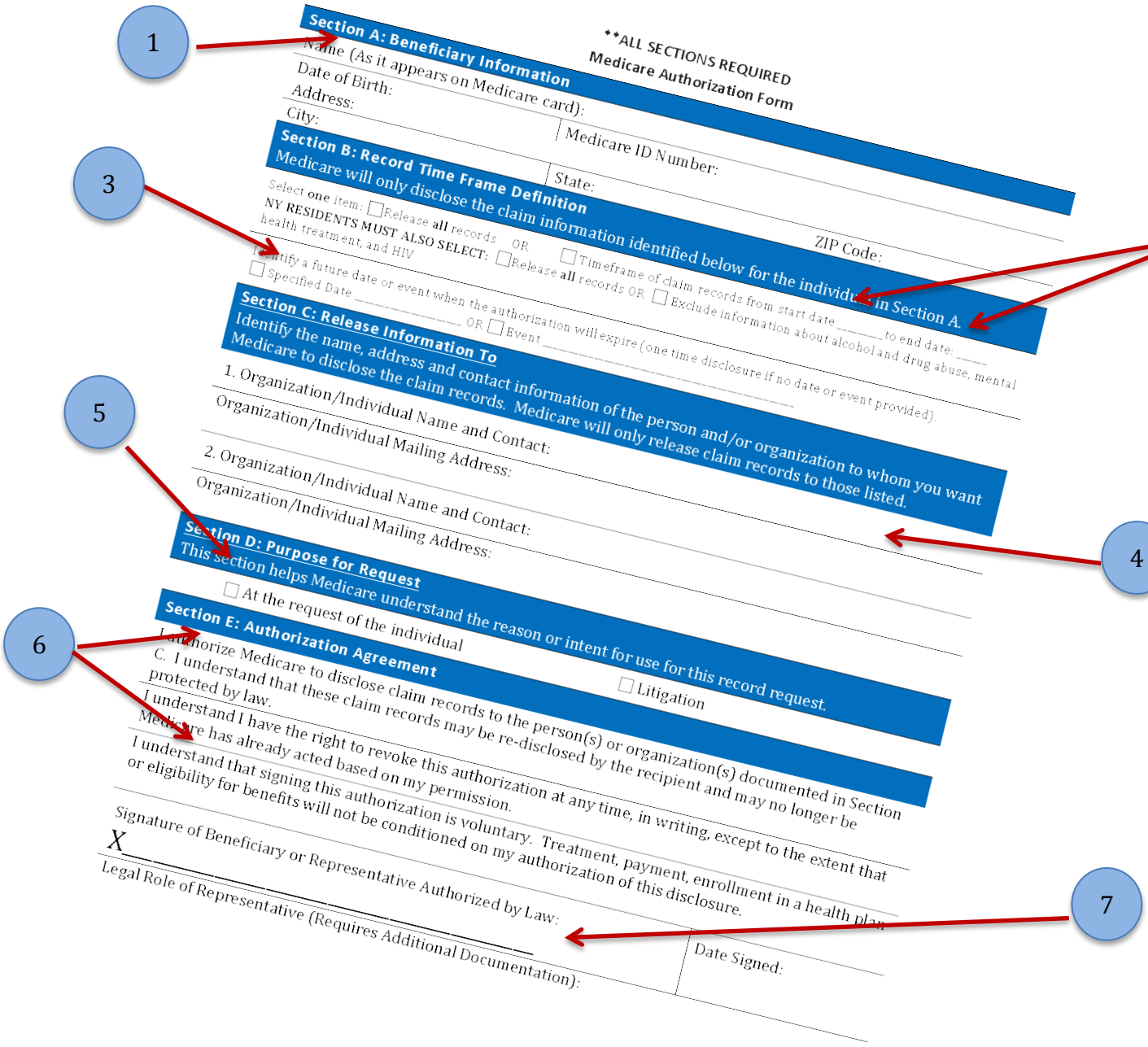
I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.

Signature of Beneficiary or Representative Authorized by Law:	Date Signed:
X_____	

Legal Role of Representative (Requires Additional Documentation):

_____ _____



1 BENEFICIARY NAME & MEDICARE NUMBER
As it appears on the Medicare Card

2 RECORD TIMEFRAME
Select date range if not selecting "ALL RECORDS"

NY Residents-additional required selection

3 SELECT EXPIRATION DATE
If specific date or event required

4 SPECIFY ORGANIZATION TO RELEASE TO
Must include contact first and last name and address

5 SELECT REASON FOR REQUEST
This includes litigation and "by request of the individual"

6 REQUIRED AUTHORIZATION CLAUSES
HIPPA clauses required to release information

7 BENEFICIARY SIGNATURE
Signed and dated by beneficiary or authorized representative (If not signed by beneficiary; note that POA or Letters Testamentary are required)