

**CONSENT TO RELEASE**

I, \_\_\_\_\_ (print name exactly as shown on Medicare card) hereby authorize the CMS, its agents and/or contractors 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:

(X) **Other:** MSA Specialists, Inc.

Name of entity: Medicare Set-Aside Specialists, Inc.  
Contact for above entity: Fran Provenzano  
Address: P.O. Box 1487  
Oldsmar, FL 34677  
Telephone: 1-866-897-4672

**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.):

(X) One Year      ( ) Two Years      ( ) Other \_\_\_\_\_

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.msprc.info](http://www.msprc.info) for further instructions.

**Medicare Health Insurance claim Number** (*Number on Medicare card*): \_\_\_\_\_

**Date of Injury/Illness:** \_\_\_\_\_