Medicare Consent to Release Form

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____ dd / mm / yyyy

Medicare Number: _____

AUTHORIZED ENTITY/INDIVIDUAL

Name: _____ **Relationship to the Client:** _____

Contact Information:

Purpose of Release:

- ◯ Personal Injury Claim
- ◯ Litigation
- ◯ Insurance Dispute
- ◯ Coordination of Benefits
- ◯ Other

Scope of Information to be Released:

- ☐ All Medical Records
- ☐ Specific Dates of Service
- ☐ Diagnostic Reports
- ☐ Treatment Plans
- ☐ Other

Duration of Authorization:

Additional Conditions/Limitations:

- ☐ No Disclosure Without Further Consent
- ☐ Limitations on Use
- ☐ Specific Recipient(s) Only
- ☐ Other

Signature of Patient/Authorized Representative:

Date: _____ dd / mm / yyyy