AUTHORIZATION AND CONSENT TO RELEASE INFORMATION PURSUANT TO HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

Individual/Claimant Name: Medicare Number:

Date of Injury: Social Security No.:

This consent effectively authorizes the below listed person/entity to represent the interests of the above-referenced Claimant regarding Claimant Workers' Compensation claims and/or Medicare/Medicaid benefits. By signing below, Claimant authorizes the disclosure of any and all information required to administer such claims and/or benefits.

PERSON/ENTITY AUTHORIZED TO RECEIVE AND USE DISCLOSED INFORMATION

Medical Expense Management, Inc.
Attn. Submissions Department
15 Davis Avenue, Suite 4
Poughkeepsie, New York 12603
Fax: 877-624-0553

INFORMATION TO BE DISCLOSED/PROVIDED

Claimant's complete medical and psychological file (including all reports, summaries, diagnoses, prognoses, histories and other records from Claimant's doctors, nurses, technicians, therapists, consultants, screeners, and all other health care or heath related personnel and facilities); Medical records from CMS (and all other health agencies) needed to complete Medicare set-Aside Allocation and costs projections; confirmation of Social Security benefits (SSD, SSI, SSR) to identify entitlement status and dates; confirmation of Medicare/Medicaid benefits and payment information to identify entitlement status and dates; insurance documents relating to settlement of claims; written authorization to obtain resolution for Medicare liens and other matters to comply with the Medicare Secondary Payor Act.

Claimant acknowledges that the information used or disclosed may be subject to re-disclosure, and in such event may no longer be protected by federal privacy regulations. Accordingly, Claimant hereby releases the Agency for Health Care Administration, and its employees and representatives, from all liability arising from the disclosure of such information hereunder.

RIGHT TO REVOKE CONSENT

This authorization is for Claimant's current workers' compensation claim and is on an ongoing basis. Claimant understands that Claimant may revoke this authorization at anytime by providing written notice the person/entity authorized above. However, no action already taken in reliance on this authorization may be reversed, and revocation will not affect such actions. Further, Claimant acknowledges that refusal to authorize disclosure will have no effect on Claimant's enrollment, eligibility for benefits or the amount of benefits to which Claimant is entitled. This authorization expires upon completion of the purpose of the intended use or disclosure of information so released.

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Claimant/Individual:

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Date

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