



Authorization for use or disclosure of protected health information pursuant to HIPAA
(Health Insurance Portability and Accountability Act of 1996)

I hereby authorize the use or disclosure of my Protected Health Information and other information as described below. I understand that this authorization is voluntary.

Individual/Claimant: _____ Individual/Claimant SSN: _____

Individual/Claimant Address: _____

DOI: _____ Medicare/HICN#: _____ Date of Birth: _____

Persons/Entities authorized to provide the information:

Any treating physicians or health care providers, any health insurance payers, the centers for Medicare and Medicaid Services, MyMedicare.gov, the Social Security Administration and my employer.

Persons/Entities authorized to receive, use and disclose the information:

Concierge Medical and Risk Consultants & Center for Medicare & Medicaid Services (CMS)
332 Holly Hill Lane
Burlington, NC 27215

Description of Information:

- All medical records, including, but not limited to, documents, reports, notes, bills, test results or radiological studies.
- Any information as may be requested by Concierge Medical and Risk Consultants from any person or entity authorized to provide the information in which, in Concierge Medical and Risk Consultant's sole discretion, is required and/or necessary to accomplish the purpose of this authorization.

Purpose of Authorization:

- This authorization is at the request of the individual/claimant for use or disclosure of information.
- To provide a full disclosure of any information to Concierge Medical and Risk Consultants, LLC, to enable it to evaluate, determine and prepare a recommended MSA (Medicare Set Aside) Arrangement, and to complete any other applicable and requested services, including Conditional Payments Research, and Final Lien Amount Demand.

I acknowledge and understand the following:

- If the person/entity authorized to receive the information is not a health plan or health care provider, the released information may not be protected by federal privacy regulations.
- My healthcare, payment of healthcare, treatment, enrollment, eligibility for benefits, or the amount Medicare pays for health services will not be affected in any way if I do not sign this authorization form.
- I may see and copy any information described in this form.
- I may copy this authorization after I sign it, and if I am unable to make a copy, I may request a copy from Concierge Medical and Risk Consultants.
- This authorization expires upon approval of the MSA Arrangement by CMS and completion of any other applicable and requested services, including Conditional Payments Research, and Final Lien Amount Demand.
- That I may revoke this Authorization at any time by written notice to Concierge Medical and Risk Consultants, LLC, however any revocation shall have no effect on actions that have been taken by Concierge Medical and Risk Consultants prior to receiving my revocation.
- Any personal medical information that I authorize Medicare to disclose could be subject to re-disclosure and no longer protected by law.
- That I have the right to refuse to sign this authorization.

I have read and understand the contents of the Authorization and have had the opportunity to discuss this authorization with the counsel of my choice. The contents of the Authorization confirm, and are consistent with, my authority, instructions, or directions to Concierge Medical and Risk Consultants, LLC, and I understand that by executing this Authorization, I am authorizing Concierge Medical and Risk Consultants, LLC, to use and disclose, as permitted and outlined herein, certain nonpublic information.

Signature of Claimant or Legal Representative

Date: _____

Relationship to Claimant if Legal Representative

(A copy of the document giving the Legal Representative the authority to sign this Authorization must be attached, except for Legal Representatives acting in capacity as a parent to the claimant.)