MEDICARE AUTHORIZATION FORM

****ALL SECTIONS REQUIRED****

SECTION A: BENEFICIARY INFORMATION

Enter beneficiary name as it appears on Medicare card.

First Name:	Middle Name:	Last Name:

Date of Birth *(mm/dd/yyyy)*	Medicare Identification Number:

Address:

City:	State:	Zip code:

SECTION B: RECORD DETAILS DEFINITION

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

Select **one** option:

- ☐ Release **all** records to date
- ☐ Release records in timeframe from start date _____ to end date: _____

NY residents only:

- ☐ Include all records
- ☐ Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Indicate whether authorization release is for a one-time disclosure, or Identify a future date or event when the authorization will expire.

Select **one** option:

- ☐ One-time disclosure
- ☒ Expiration upon specified date _____
- ☐ Expiration upon specified 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.

☐ Release claim records to beneficiary at mailing address above.

Organization/Individual 1 Name	Recipient 1 Email Address
CD SERVICES, INC.	RECORDS@CDSERVICESINC.COM

Recipient 1 Mailing Address:

24027 RESEARCH DRIVE FARMINGTON HILLS, MI 48335

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:

Legal Role of Representative (Requires Additional Documentation):