Medicare Consent to Release Form

Patient Information
Name:
Date of Birth:
Medicare Number:
Authorized Entity/Individual
Name:
Relationship to Patient:
Contact Information:
Purpose of Release
☐ Personal Injury Claim
☐ Litigation
☐ Insurance Dispute
☐ Coordination of Benefits
☐ Other (specify):
Scope of Information to be Released
☐ All Medical Records
☐ Specific Dates of Service
☐ Diagnostic Reports
☐ Treatment Plans
☐ Other (specify):
Duration of Authorization
This authorization is valid for ___ months/years from the date of signature unless revoked earlier.
Additional Conditions/Limitations
☐ No Disclosure Without Further Consent
☐ Limitations on Use
☐ Specific Recipient(s) Only
☐ Other (specify):
Signature of Patient/Authorized Representative:
Date: