

## CONSENT TO RELEASE

I, \_\_\_\_\_ (print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

**CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:** (If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

Insurance Company       Workers' Compensation Carrier       Other: MEDVAL, LLC

Name of entity: MEDVAL, LLC  
Contact for above entity: Anna-Marie Sorrento  
Address: 8860 Columbia 100 Parkway, Suite 308  
Columbia, MD 21045  
Telephone: (410) 740-3084

**CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION:** (The period you check will run from when you sign and date below.)

One Year       Two Years       Other \_\_\_\_\_ (Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

### MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit [www.msprc.info](http://www.msprc.info) for further instructions.

Medicare Health Insurance claim Number (The number on your Medicare card): \_\_\_\_\_

Date of Injury/Illness: \_\_\_\_\_