

# Allsup, Inc.

## Authorization for Release of Information

I, \_\_\_\_\_, authorize Allsup, Inc. and any employee of Allsup, Inc. (collectively "Allsup") to disclose to and/or discuss with the Centers for Medicare & Medicaid Services, the Social Security Administration and such other persons or entities as Allsup may determine to be necessary or desirable to provide its services, any and all information, materials and/or documents, which Allsup has or may develop or acquire and which, in any way, pertain to me (collectively "Information") for the following purposes:

- (i) any matter related to the commutation, compromise and/or settlement of my claim(s);
- (ii) any matter related to the evaluation, preparation, establishment, funding, approval, administration and/or any other aspect of a Medicare set-aside arrangement for me; and/or
- (iii) any matter related to Social Security Disability Insurance benefits, Medicare benefits, Workers' Compensation benefits and/or any other benefits for which I am or may be eligible.

I understand that such Information may include, but is not limited to, any and all Information pertaining to my Medicare eligibility and my medical condition, past, present and/or future, including history, findings, diagnostic test results, diagnosis and prognosis.

I agree that a copy or facsimile (fax) of this authorization shall be as valid as this original for all purposes and that this authorization shall remain in effect, unless it shall expire or is revoked in the manner described below.

This authorization shall expire 120 days after the completion by Allsup of all its services, unless earlier revoked in the manner described below.

I understand that this authorization is voluntary and that I may revoke this authorization at any time. My revocation must be provided in writing, by giving or mailing a letter to Allsup at 300 Allsup Place, Belleville, IL 62223-8626, Attention: MSA Department and will be effective three business days after its receipt by Allsup.

I agree that no expiration or revocation of this authorization shall invalidate or otherwise adversely affect any action or right taken or exercised, in whole or in part, in reliance upon this authorization prior to such expiration or revocation.

I agree that this authorization is in addition to any other authorizations (express or implied) I have provided or may provide in the future and understand that I may request a copy of this authorization from Allsup at any time.

If I am signing this authorization on behalf of the claimant, I represent and warrant to Allsup that I have complete authority to do so.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship, if signing on behalf of claimant

**Social Security Administration**  
**Consent for Release of Information**

Form Approved  
OMB No. 0960-0566

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**Instructions for Using this Form**

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor, you may complete this form to release only the minor's non-medical records. If you are requesting information for a purpose not directly related to the administration of any program under the Social Security Act, a fee may be charged.

**NOTE:** Do not use this form to:

- Request us to release the medical records of a minor. Instead, contact your local office by calling 1-800-772-1213 (TTY-1-800-325-0778), or
- Request information about your earnings or employment history. Instead, complete form SSA-7050-F4 at any Social Security office or online at [www.ssa.gov/online/ssa-7050.pdf](http://www.ssa.gov/online/ssa-7050.pdf).

**How to Complete this Form**

We will not honor this form unless all required fields are completed. An asterisk (\*) indicates a required field. Also, we will not honor blanket requests for "all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the information applies.
- Fill in the name and address of the individual (or organization) to whom you want us to release your information.
- Indicate the reason you are requesting us to disclose the information.
- Check the box(es) next to the type(s) of information you want us to release including the date ranges, if applicable.
- You, the parent or legal guardian acting on behalf of a minor, or the legal guardian of a legally incompetent adult, must sign and date this form and provide a daytime phone number where you can be reached.
- If you are not the person whose information is requested, state your relationship to that person. We may require proof of relationship.

**PRIVACY ACT STATEMENT**

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. The information you provide will be used to respond to your request for SSA records information or process your request when we release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent.

We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, in accordance with 5 U.S.C. § 552a(b) of the Privacy Act, we may disclose the information provided on this form in accordance with approved routine uses, which include but are not limited to the following: 1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; 3. To comply with Federal laws requiring the disclosure of the information from our records; and, 4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and other Social Security programs are available from our Internet website at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at your local Social Security office.

**PAPERWORK REDUCTION ACT STATEMENT**

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at [www.socialsecurity.gov](http://www.socialsecurity.gov). Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

**Social Security Administration**  
Consent for Release of Information

Form Approved  
OMB No. 0960-0566

SSA will not honor this form unless all required fields have been completed (\*signifies required field).

TO: Social Security Administration

\_\_\_\_\_  
\*Name

\_\_\_\_\_  
\*Date of Birth

\_\_\_\_\_  
\*Social Security Number

I authorize the Social Security Administration to release information or records about me to:

\_\_\_\_\_  
\*NAME

\_\_\_\_\_  
\*ADDRESS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*I want this information released because: \_\_\_\_\_ requires verification

*There may be a charge for releasing information.*

of filing and/or receipt of Social Security benefits. This Consent for Release of Information shall

remain in effect for two years from the date it is signed below.

\*Please release the following information selected from the list below:

*You must check at least one box. Also, SSA will not disclose records unless applicable date ranges are included.*

- Social Security Number
- Current monthly Social Security benefit amount
- Current monthly Supplemental Security Income payment amount
- My benefit/payment amounts from \_\_\_\_\_ to \_\_\_\_\_
- My Medicare entitlement from \_\_\_\_\_ to \_\_\_\_\_
- Medical records from my claims folder(s) from \_\_\_\_\_ to \_\_\_\_\_  
*If you want SSA to release a minor's medical records, do not use this form but instead contact your local SSA office.*
- Complete medical records from my claims folder(s)
- Other record(s) from my file (e.g. applications, questionnaires, consultative examination reports, determinations, etc.) \_\_\_\_\_  
Date or most recent date of SSDI; Date or Alleged Date of Onset; Date of Entitlement to SSDI benefits; Date of Entitlement to Medicare; Current Status for SSDI benefits. Date of denial for SSDI benefits; Amount of worker initial entitlement; Auxiliary beneficiary information; SSA offset information.

I am the individual to whom the requested information/record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury in accordance with 28 C.F.R. § 16.41(d)(2004) that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to \$5,000. I also understand that any applicable fees must be paid by me.

\*Signature: \_\_\_\_\_ \*Date: \_\_\_\_\_

Relationship (if not the individual): \_\_\_\_\_ \*Daytime Phone: \_\_\_\_\_



### CONSENT TO RELEASE FORM

I, \_\_\_\_\_ hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement to the individual(s) and/or firm(s) listed below:

PLEASE CHECK:

- Claimant's attorney \_\_\_\_\_  
(Name and/or firm)
- Insurance carrier \_\_\_\_\_  
(Name and/or company)  
Consultant: Allsup, Inc. \_\_\_\_\_
- Other <sup>Consultant &</sup> ~~Insurer's Law Firm~~ \_\_\_\_\_  
(Explain) (Law Firm Name)

How long can we give out the information? **(Check one Block)**

- Ongoing, beginning \_\_\_\_\_  
Month/Date/Year
- Limited time \_\_\_\_\_ through \_\_\_\_\_  
Month/Date/Year Month/Date/Year
- One time only

\_\_\_\_\_  
Claimant's Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Date of Injury

\_\_\_\_\_  
Medicare Number

**If your Power of Attorney (POA) or legal representative signs this form for you, a copy of their POA or representation papers must be sent to us with this form.**

Completion and signing of this consent form:

Authorizes release of information to the person named above upon their request. This means that information disclosed to the above named person may be re-disclosed by them and may no longer be protected by law.

Allows release of Medicare claims and other information related to your injury/illness.

Is for release of information purposes only and does not affect benefits you are entitled to under the Medicare Program.

You have the right to revoke your authorization at any time in writing, except to the extent that CMS has already acted based on your permission. To revoke, send a written request to the address below.

**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:** (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 \_\_\_\_\_  
(Explain)

Name of entity: \_\_\_\_\_

Contact for above entity: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

**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: \_\_\_\_\_