Medicare Authorization To Disclose Personal Health Information

1.	Print Y	Your Name	Your Medicare Number	Your Date of Birth			
2.	Check <u>one or more boxes</u> to tell Medicare the specific personal health information you want disclosed. Medicare will only disclose the personal health information you check below.						
		Information about a medic B, and/or C below:	Information about a medical service or medical services you received. Fill in A B, and/or C below:				
		A. One medical service of From this doctor or sup	n this date: oplier:	· 			
	•	B . All medical services or	n the following date(s): _	· · · · · · · · · · · · · · · · · · ·			
		C. All medical services from these doctor(s) or supplier(s):					
	. 🗖	Information about your Medicare eligibility					
	. 🗆	Information on your other health coverage					
		Information on your deductible for the year(s) of:					
		Copy of your Medicare Summary Notice for					
		Date of Medical Service	Doctor or Supplier	Hospital or Facility			
:		Other personal health infor	rmation:				
3. ·	pers	ck only <u>one</u> for how long Nonal health information (so the how long Medicare may gi	ubject to applicable law—	for example, your State may			
		Disclose my personal heal	th information this one time	me only.			
1	<u> </u>	Start disclosing my person Stop disclosing my person					
di T		Disclose my personal heal example, while you are enhospital).		ration of an event (for the plan or while you are in a			
i		What is the event:					

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I authorize Medicare to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s and may no longer be protected by law.					
Sign Your Nam	e	Your Telephone	Number D	ate	
	,	as a personal represe or example, Power of		attach the	

You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Your refusal to authorize this disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

If you need help with this form, call 1-800-MEDICARE (1-800-633-4227).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0930. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21224-1850.