OMB no. 0938-0930

Medicare Authorization to Disclose Personal Health Information

Use this form to ask Medicare to give out (disclose) your personal health information to the individual or organization you choose.

Section 1

Print Person with Medicare's First & Last Name	Medicare Number	Date of Birth (mm/dd/yyyy)

Print person with Medicare's first and last name as shown on the Medicare card.

Section 2

Medicare will only disclose the personal health information you want disclosed.

Check (✓) box 2A *or* 2B. *Do not check both boxes*.
New York residents must also complete Box 2C.

☐ 2A - **I want Medicare to release any information.**

OR

For limited disclosure of information, check the box 2B below and select the appropriate information to tell Medicare the specific personal health information you want disclosed:

☐ 2B – **I want Medicare to ONLY release the limited information checked below:**

Check all that apply.

- o Information about your Medicare eligibility
- o Information about your Medicare claims
- o Information about plan enrollment (e.g. drug or MA plan)
- o Information about premium payments

Other specific information printed on the line below. ***If this box is checked, you must include a description of information to be released or the request cannot be processed.)***

2C - **NY Residents Only,** ***this section must be completed.)***
Please select one of the following options**:**
(Please check only one box.)

☐ a) Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

OR

☐ b) Exclude information about alcohol and drug abuse, mental health treatment, and HIV.

Section 3

How long should Medicare release the information to the authorized individuals or organization? *(This is subject to applicable law – for example, your state may limit how long Medicare may give out your personal health information.)*

Check only one box.

☐ a) Disclose my personal health information indefinitely.

OR

☐ b) Disclose my personal health information for a specified period:

_____ _____
Beginning date (mm/dd/yyyy) Ending date (mm/dd/yyyy)

(***If selecting b, you must include a stop and start date or the request cannot be processed.)***

Section 4

Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information in the section(s) below.

- ✓ ***If you need to list additional names, you may attach a sheet of paper to this form. (Include your name and Medicare number on the additional sheet.)***
- ✓ ***Please provide the specific name of the person(s) for any organization you listed below:***

Name:	
Address: (required)	

Name:	
Address: (required)	

Name:	
Address: (required)	

Section 5

I authorize Medicare to disclose my personal health information listed in section 2 to the person(s) and/or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) and/or organization(s) and may no longer be protected by law.

_____	_____	_____
Signature	Telephone Number	Today's Date (mm/dd/yyyy)

Print the **person with Medicare's** current address (street address, city, state and ZIP Code):

_____

_____

If the person with Medicare signs section 5 above, do not complete section 6.

Section 6 - For Personal Representative Only

Important information: This section should only be completed if someone other than the person with Medicare signs in section 5.

☐ Check here if you are signing as a personal representative of the person with Medicare and complete the information below. Please attach the appropriate legal documentation (for example, Power of Attorney or Executorship). ***See the instructions on submitting the appropriate legal documents.***

Signature: _____

Print the personal representative's address (street address, city, state and ZIP Code):

_____

_____

Personal representative's telephone number: _____

You should make a copy of your signed authorization for your records before mailing it to Medicare.

Send the completed, signed authorization to:

Medicare BCC, Written Authorization Dept.

P.O. Box 1270

Lawrence, KS 66044

Note:

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

PRA Disclosure Statement

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-XXXX**. The time required to complete this information collection is estimated to average **[Insert Time (hours or 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE**.