

Medicare Authorization To Disclose Personal Health Information

Use this form to ask Medicare to give out (disclose) your personal health information.

1. Print Your Name _____ Your Medicare Number _____ Your Date of Birth _____

2. Check one or more boxes 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 medical service or medical services you received. Fill in A, B, and/or C below:

A. One medical service on this date: _____
From this doctor or supplier: _____

B. All medical services on 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 information: _____

3. Check only one for how long Medicare can use this authorization to disclose your personal health information (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

Disclose my personal health information this one time only.

Start disclosing my personal health information on this date: _____
Stop disclosing my personal health information on this date: _____

Disclose my personal health information for the duration of an event (for example, while you are enrolled in a Medicare health plan or while you are in a hospital).

What is the event: _____

4. **Fill in the reason for the disclosure** (you may write “at my request”):

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

6. 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 Name

Your Telephone Number

Date

Check here if you are signing as a personal representative. Please attach the appropriate documentation (for example, Power of Attorney).

7. **Send your completed, signed authorization to:**

8. **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 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.