OMB 0938 - 0930

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 <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 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 <u>one</u> 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).