

Medicare Information Release Form

By law, Medicare is required to protect your personal medical information.

Medicare has the right to use and give out (“disclose”) your personal medical information to pay for your health care and to operate the Medicare program. For any other purpose, Medicare may only disclose your personal medical information with your written permission (“authorization”).

Please understand refusal to sign this authorization will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

Remember your personal medical information that you authorize Medicare to disclose may be subject to re-disclosure and no longer protected by law if the person that you authorized releases this information.

You can authorize Medicare to disclose your personal medical information by completing **Items 1-5**, signing the form and sending it to:

**Palmetto GBA
P.O. Box 100297
Columbia, SC 29202-3297**

Telephone: 1-800-MEDICARE (1-800-633-4227); 1-877-486-2048 TDD (for hearing impaired)

Medicare Information Release Form

1. _____ - - - - -
Name of Beneficiary Medicare Number (letter)

2. I authorize Medicare to disclose this personal medical information: (Please check one or more):

- All Medicare information
- One service only: Date of service: _____
Doctor/supplier: _____
- All services on these date(s): _____

- All services from these doctor(s) or supplier(s):

- Other (please specify): _____

➔ over

3. I authorize Medicare to disclose this personal medical information to: (This may be a person, agency, company or organization).

Name: _____

Address: _____

4. Purpose of the disclosure:

- At the request of the individual (if you don't want to provide a statement of purpose)
- Other: _____

5. Time period, subject to applicable law (Please check one):

- Duration of Medicare enrollment
- One time release
- Ongoing release from: _____ to _____

Signature of Beneficiary or Authorized Representative*

Date

*If you are signing as an authorized representative, please describe the basis for your authority to act for the beneficiary and attach appropriate documentation (for example, Power of Attorney or Appointment of Representative).

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. To revoke your authorization, send a written request to:

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