



Consent to Release Form

The Privacy Act of 1974(Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I, _____, (print your name exactly as shown on your Medicare card) hereby authorize the Centers for Medicare and Medicaid Services(CMS), its agents and/or contractors to disclose, discuss, and release, orally and in writing, information related to my illness/injury claim and settlement to the firm listed below. This consent is ongoing until I revoke this consent in writing. Further, I have had the Medicare Set-Aside Arrangement need and process explained to me by my claim or attorney representative, and I approve of the contents of the submission. **(CLAIMANT/BENEFICIARY INITIALS: _____)**

Insurance Company

Worker's Compensation Carrier

OTHER/MSP Vendor:

**Axiom National, LLC
13046 Race Track Road, # 277
Tampa, FL 33626
Phone 888-826-6496; Fax 813-920-6946**

Claimant's Signature: _____

SSN/Medicare Beneficiary ID#: _____

Date of Illness/Injury _____

Date Signed: _____

AXIOM NATIONAL, LLC

13046 Race Track Road, # 277 , Tampa, FL 33626

Phone 888-826-6496; Fax 813-920-6946