

**CONSENT TO RELEASE FORM**

CMS Case Control Number: \_\_\_\_\_

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, \_\_\_\_\_, hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to disclose, discuss, and/or release, orally or in writing, information related to my **workers' compensation injury and/or liability** settlement to the individual(s) and/or firm(s) listed below. This consent is for my current **workers' compensation or liability claim** and is on an ongoing basis. An additional consent to release form will not be necessary unless or until I revoke this authorization (which must be in writing).

PLEASE CHECK:

Claimant's attorney \_\_\_\_\_  
(name and/or firm)

Employer's attorney \_\_\_\_\_  
(name and/or firm)

Workers' compensation carrier \_\_\_\_\_  
(name and/or firm)

Other Specialty Allocations, Inc. \_\_\_\_\_  
(name and/or firm)

\_\_\_\_\_  
Claimant's Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Date of Injury

\_\_\_\_\_  
Social Security Number Or  
Health Insurance Claim Number