



7752 Cooley Lake Road
Waterford, MI 48327
Office 248.360.9952
Fax 248.360.6142
mr@tenon-group.com

Consent to Release

This form should be used by you, a Medicare beneficiary, to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare and Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation insurance claim.

I, _____ (print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

Tenon Group PC

Firm Name: Tenon Group PC

Address: 7752 Cooley Lake Road
Waterford, MI 48327

Telephone: (248) 360-9952 Fax: (248) 360-6142

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign and date below):

One year Two years (Other) _____
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing, sent to the above address.

Medicare Beneficiary Information and Signature / Date:

Beneficiary Signature: _____ Date signed: _____

Beneficiary's Health Insurance Claim Number (number on your Medicare card): _____

Date of Illness/Injury for which the beneficiary has filed a claim: _____