SANDERSON FIRM AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA AND APPOINTMENT OF REPRESENTATIVE

(Health Insurance Portability and Accountability Act of 1996)

I hereby authorize the use or disclosure of my Protected Health Information and other information as described below. I understand that this authorization is voluntary.

Individual/Claimant:	Individual/Claimant SSN:
Individual/Claimant Address:	
Date of Birth:	Date of Injury:

Persons/ Entities authorized to provide the information:

Any health plan, physician, healthcare professional, hospital, clinic, laboratory, holders of prescription information, including but not limited to, pharmacies, pharmacy benefit managers, and insurers, medical facility, employer, health insurance payers, the Centers for Medicare & Medicaid Services and its contractors, MyMedicare.gov, Social Security Administration, Medicaid, or any other healthcare professional that has provided payment, treatment or services to me or on my behalf.

Persons/ Entities authorized to receive, use, and disclose the information:

1. Sanderson Firm PLLC
   1001 Third Avenue West, Suite 400
   Bradenton, FL 34205
2. Centers for Medicare & Medicaid Services
3. Designated private Medicare Advantage Plan or Prescription Drug Plan as contracted through Medicare (CMS

Description of Information:

1. Entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information, bills, insurance coverage information and any other protected health information concerning me. This includes information on the diagnosis and/or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.
2. Any information as may be requested by Sanderson Firm from any person/entity authorized to provide the information, which, in Sanderson Firm's sole discretion, is required or necessary to accomplish the purpose of this Authorization.

Purpose of Authorization:

1. This Authorization for use or disclosure of information is at the request of the individual/claimant.
2. To provide a full disclosure of any information to Sanderson Firm, to enable it to evaluate, determine, and prepare a recommended Medicare Set-Aside, and to complete any other applicable and requested services, including Conditional Payments (Medicare Lien) Research, Final Lien Amount Demand and Lien Negotiation, Medicaid or Medicare Advantage Plan lien research and negotiation.
3. To designate Sanderson Firm as its representative to have the authority to communicate with CMS and its contractors, a state Medicaid agency and any private Medicare Advantage Plan or Prescription Drug Plan (as specifically designated above) to obtain Conditional Payment information and to dispute or negotiate, on my behalf, any request for Conditional Payment Reimbursement related to the undersigned Medicare beneficiary.

I acknowledge and understand the following:

1. That if the person or entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations;
2. That my health care, payment of health care, treatment, enrollment, eligibility for benefits, or the amount Medicare pays for the health services will not be affected if I do not sign this authorization form;
3. That I may see and copy any information described in this form;
4. That I may copy this Authorization after I sign it, and if I am unable to make a copy, I may request a copy from Sanderson Firm ;
5. That I may revoke this Authorization at any time by written notice to Sanderson Firm, but that any revocation shall have no effect on actions which have been taken by Sanderson Firm prior to receiving my revocation;
6. That any personal medical information that I authorize to disclose may be subject to re-disclosure and no longer protected by law;
7. That I have the right to refuse to sign this Authorization.
8. This Authorization will expire two (2) years from the date the form is signed (unless evoked prior by written notice)

I have read and understand the contents of this Authorization and have had the opportunity to discuss same with counsel of my choice. The contents of this Authorization confirm, and are consistent with, my authority, instructions, or directions to Sanderson Firm, and I understand that by executing this Authorization, I am authorizing Sanderson Firm, to use and disclose, as permitted and outlined herein, certain nonpublic information. Further, I have had the Workers' Compensation Medicare Set Aside Arrangement need and process explained to me, and I approve of the contents of the submission.

THIS FORM MUST BE SIGNED AND INITIALED BY THE CLAIMANT OR LEGAL REPRESENTATIVE TO BE VALID

Claimant Initials_____ Date: _____

_____ _____

Signature of Claimant or Legal Representative Relationship to Claimant if Legal Representative

(Except for Legal Representatives acting in their capacity as a parent to the claimant, a copy of the document giving the Legal Representative authority to sign this Authorization must be attached.)

**In the case where a minor child is the claimant, the release MUST have the child's SS# on it but signed by the Parent or Legal Guardian.*