CONSENT TO RELEASE

I, ___________________________ hereby authorize The Centers for Medicare & Medicaid Services
(Print Name)
(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:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

( ) Workers' Compensation Carrier ( ) Liability Carrier ( ) My Attorney
(X) Other: MSPRC investigator

Name of Individual/Entity: Angelo Paul Sevarino, Esq.

Address: 26 Barber Hill Road, Broad Brook, CT 06016

Telephone: 860-870-3803

THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign the 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.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE

Beneficiary Signature: __________________________ Date Signed: ___________________

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit www.msprc.info for further instructions.

Medicare Health Insurance Claim Number (The number as shown on your Medicare card):

□□□-□□-□□□□-□□

____
Date of Injury/Illness