

GOULD & LAMB, LLC
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED
HEALTH INFORMATION PURSUANT TO HIPAA
(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: _____

DOI: _____ Medicare/HICN #: _____ Date of Birth: _____

Persons/ Entities authorized to provide the information:

Any treating physicians or health care providers, my Employer, any Health Insurance Payors, the Centers for Medicare & Medicaid Services, MyMedicare.gov, Social Security Administration

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

1. Gould & Lamb, LLC
101 River Front Blvd. Suite 100
Bradenton, Florida 34205
2. Centers for Medicare & Medicaid Services(CMS)

Description of information:

1. All medical records, including, but not limited to, documents, reports, notes, bills, test results or x-rays.
2. Any information as may be requested by Gould & Lamb from any person/ entity authorized to provide the information, which, in Gould & Lamb'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 Gould & Lamb, LLC, to enable it to evaluate, determine, and prepare a recommended Medicare Set-Aside Arrangement, and to complete any other applicable and requested services, including Conditional Payments (Medicare Lien) Research, Final Lien Amount Demand and Lien Negotiation.

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 Gould & Lamb;
5. That this authorization expires upon approval of the Medicare Set-Aside Arrangement by CMS and completion of any other applicable and requested services, including Conditional Payments (Medicare Lien) Research, Final Lien Amount Demand and Lien Negotiation;
6. That I may revoke this Authorization at any time by written notice to Gould & Lamb, LLC, but that any revocation shall have no effect on actions which have been taken by Gould & Lamb prior to receiving my revocation;
7. That any personal medical information that I authorize Medicare to disclose may be subject to re-disclosure and no longer protected by law;
8. That I have the right to refuse to sign this authorization.

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 Gould & Lamb, LLC, and I understand that by executing this Authorization, I am authorizing Gould & Lamb, LLC, to use and disclose, as permitted and outlined herein, certain nonpublic information.

Signature of Claimant or Legal Representative

Date: _____

Relationship to Claimant if Legal Representative

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