Medicare

Authorization to Disclose Personal Health Information Release Form

Use this form to give 1-800-MEDICARE permission to share your personal health information with someone other than you.

You can also use this form to get information for someone who is deceased (if you legally have the right to that information because you're an Executor, or you have court documents giving you rights to that information.)

> By law, you must give 1-800-MEDICARE permission in writing before 1-800-MEDICARE can share any information with someone other than you. For the full list of how 1-800-MEDICARE uses your information, see the privacy notice in the *Medicare & You* handbook, or visit **Medicare.gov** and search for "privacy practices."

Submit your form online or by mail

- For faster service, submit this form online by logging in to your secure **Medicare.gov** account.
- Or, mail your completed and signed authorization form to:

  1-800-MEDICARE Written Authorization Dept.
  PO Box 1270
  Lawrence, KS 66044

If you're requesting personal health information for a deceased person who had Medicare, include a copy of the legal documentation that gives you the authority to get this information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.)

How to cancel your Authorization to Disclose

You have the right to change or cancel ("revoke") your authorization at any time. If you change your mind later and no longer want us to share your personal health information, write to the address above and tell us. Your letter will cancel your authorization form, and we'll no longer share your personal health information (except for any information we already released based on your original permission).

Get help with this form

If you have questions or need help with this form, call us at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Get information in another format

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Form Approved
OMB No. 0938-0930

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Information about the person with Medicare

First name | Middle name | Last name | Suffix

Medicare Number ___-___-___

Date of birth (mm/dd/yyyy) __/__/____

Mailing address (number and street, P.O. Box, or route)

City | State | ZIP code

Phone number (___)___-____

Email address

Enter the name of each person or organization that can get your personal health information from 1-800-MEDICARE

To share with more than 2 people or organizations, list their name and address on the back of this form.

Person/Organization 1 (full name)

Mailing address (number and street, P.O. Box, or route)

City | State | ZIP code

Person/Organization 2 (full name)

Mailing address (number and street, P.O. Box, or route)

City | State | ZIP code

Choose the information you want 1-800-MEDICARE to share.

Check only one box:

- ◯ Any information
- ◯ Limited information

If you selected "limited information," let us know the types of personal health information you want us to share. Check all that apply:

- ◯ Medicare eligibility
- ◯ Medicare claims
- ◯ Health & drug plan enrollment
- ◯ Premium payments
- ◯ Other (Write any other information you want shared below. For example, payment information):

For New York Residents Only

The New York State Public Health Law protects the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV. Do you give your permission to share this information?

◯ **Yes, I give 1-800-MEDICARE permission to share information** about alcohol and drug abuse, mental health treatment, or HIV.

◯ **No, I DON'T give 1-800-MEDICARE permission to share information** about alcohol and drug abuse, mental health treatment, or HIV.

How long can 1-800-MEDICARE use this authorization to share your personal health information*?

Check one:

◯ Share my personal health information **indefinitely**.

◯ Share my personal health information only for this period of time:

Start date: ☐☐/☐☐☐☐ End date: ☐☐/☐☐☐☐

*Your state may have different limits on how long Medicare can share your personal health information.

Explain why you're giving 1-800-MEDICARE permission to share your information.
(You can write "At my request.")

Signature

By signing this form, I authorize 1-800-MEDICARE to share my personal health information listed above to the person(s) or organization(s) I named on this form. I understand that my personal health information may be shared by the person(s) or organization(s) and may no longer be protected by law.

Signature	Date signed (mm/dd/yyyy)
	☐☐/☐☐/☐☐☐☐

Personal Representative Information

◯ Check here if you're signing as a personal representative and complete the fields below.

◯ Attach a copy of the paperwork that shows you can act for the person (like a Power of Attorney).

Personal representative's first name	Middle name	Last name	Suffix

Mailing address (number and street, P.O. Box, or route)

City	State	ZIP code
	☐☐	☐☐☐☐☐

Phone number	Relationship to the person with Medicare
(☐☐☐)☐☐☐-☐☐☐☐	

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