GENEX Services, LLC
Authorization to Use or Disclose Protected Health Information

I authorize any representative of GENEX Services, LLC to obtain and disclose information including, but not limited to, information from any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service that has information about my health.

I authorize any representative of GENEX Services, LLC to contact and disclose information to Medicare/CMS, Social Security, and Medicaid.

I authorize any representative of GENEX Services, LLC to obtain and disclose information including, but not limited to, information from any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility and information pertaining to my Social Security, and Medicare entitlement to my Worker's Compensation Carrier.

I authorize any representative of GENEX Services, LLC to obtain and disclose information including, but not limited to, information from any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility to a structured settlement broker for the purpose of obtaining a rated age.

Information about my health may relate to any disorder of the immune system including, but not limited to; HIV and AIDS, use of drugs and alcohol, mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I, , hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to disclose, discuss, and/or release orally or in writing, information related to my claim and/or settlement to the individual(s) and/or firm(s) listed below. This consent is for my current claim and is on an ongoing basis. An additional consent to release form will not be necessary unless or until I revoke this authorization.

I understand any information GENEX obtains pursuant to this authorization will be used to complete a future medical allocation or be used in relation to the submission of a Medicare Set Aside. I further understand that the information is subject to re-disclosure and might not be protected by certain federal regulations governing the privacy of health information.

A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization at any time by sending written notice to GENEX at the below address. Any revocation shall have no effect on actions taken by GENEX prior to receipt of the revocation. This authorization will expire two (2) years from the date signed below.

_____ _____

(Signature of Claimant/Patient) (Date Signed)

_____ _____

(Name – Please Print) (Social Security Number)

I, _____, signed on behalf of the claimant/patient as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

GENEX MSA Department
440 E. Swedesford Road, Suite 1000
Wayne, PA 19087