CONSENT TO RELEASE

I, _____________________________ (print claimant's name exactly as shown on Medicare card) hereby authorize the 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.)

( ) Insurance Company ( ) Workers' Compensation Carrier (X) Other:

Name of entity: Sharpline Allocations (Medicare Set Aside Allocators)

Contact for above entity: Wendy Schreck, MSCC

Address: 2201 Long Prairie Rd., Suite 107, #628, Flower Mound, TX 75022

Telephone: (561) 445-8280; Facsimile: (561) 393-6630

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION (The period you check will run from when you sign and date below.)**:**
( ) One Year (X) 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 on your Medicare card): _____________________

Date of Injury/Illness: ___________________