MSA ADVOCATES, INC.
505 East Fayette Street, Suite 214 – Syracuse, New York 13202
Phone: (315) 472-7965 Fax: (315) 472-2616

Dated: _____

To:

Re:

To Whom It May Concern:

Please let this serve as authorization for you to speak with and/or provide any medical information requested by MSA Advocates, Inc. with regard to my accident and/or occupational exposure that took place on _____.

It is my understanding that MSA Advocates, Inc. is requesting this information with regard to the Medicare set aside and lien/conditional payment search that is required for the settlement of my insurance claim(s).

I further understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) set standards for guaranteeing the privacy of my individual identifiable health information and the confidentiality of my patient medical records. By completing and signing this form, I authorize my health care provider and/or the insurance carrier, and/or my attorney or representative to provide medical reports to the above party, MSA Advocates, Inc. for the purposes of completing the Medicare set aside required by Federal Law/Rules for the settlement of my insurance claim(s). I understand that I am entitled to a copy of this authorization should I request the same.

_____
Claimant

_____
Date

_____

Witness Signature