Medicare Privacy Authorization Form

Use this form if you want 1-800-Medicare to give your personal health information to someone other than you.

1. Print Name ____________ Medicare Number ____________ Date of Birth ____________
(First and last name of the person with Medicare) (Exactly as shown on the Medicare Card) (mm/dd/yyyy)

2. Medicare will only disclose the personal health information you want to disclose.

2A: **Check only <u>one</u> box below to tell Medicare the specific person health information you want disclosed:**

☐ Limited Information (go to question 2b)

☐ Any Information (go to question 3)

2B: **Complete <u>only</u> if you selected "limited information". Check all that apply:**

☐ Information about your Medicare eligibility

☐ Information about your Medicare claims

☐ Information about plan enrollment (e.g. drug or MA plan)

☐ Information about premium payments

☐ Other Specific Information (please write below; for example, payment information)

____

3. **Check only <u>one</u> box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law- for example, your State may limit how long Medicare may give out your personal health information):

☐ Disclose my personal health information indefinitely

☐ Disclose my personal health information for a specified period only beginning: (mm/dd/yyyy) ____________ and ending: (mm/dd/yyyy) ____________

4. **Fill in the name and address of the person(s) or organizations(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:**

1. Name: Stephens & Stephens
   Address: 6310 Olde Pecan Drive, Suite 200
   Richmond, Texas 77406

2. Name: ______________________________
   Address: ______________________________
   ____

3. Name: ______________________________
   Address: ______________________________
   ____

5.

I authorize 1-800- MEDICARE to disclose my person health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

______________________ ( ) - ______________ ______________

Signature Telephone Number Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

____

____

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

____

____

Telephone Number of Personal Representative: ______________________

Personal Representative's Relationship to the Beneficiary: ______________________