



Consent to Release Form

The Privacy Act of 1974(Public Law 93-579) prohibits the government from revealing information from personal files without the express written permission of the person involved. Disclosure of personal records to an attorney or other representative who is acting on behalf of another person is prohibited, unless the individual to whom the record pertains has consented.

I, _____,(print your name exactly as shown on your Medicare card) hereby authorize the Centers for Medicare and Medicaid Services(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.

Insurance Company Worker’s Compensation Carrier Other: **Service Provider – Vendor:**

Axiom National, LLC
Geoffrey C. Hudson, CEO
13046 Race Track Road, # 277
Tampa, FL 33626
813-600-0704 P; 813-920-6946 F

Check One of the Following to Indicate How Long CMS May Release Your Information”

One Year 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:

Claimant’s Signature: _____

HICN: _____

Date of Injury/Illness: _____

Today’s Date: _____