FRANCO SIGNOR, LLC
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED
HEALTH INFORMATION PURSUANT TO HIPAA AND APPOINTMENT OF REPRESENTATIVE
(Health Insurance Portability and Accountability Act of 1996)

I hereby authorize the use or disclosure of my Protected Health Information and other information as described below. I understand that this authorization is voluntary.

Individual/Claimant: _____ Individual/Claimant SSN: _____

Individual/Claimant Address: _____

Medicare/HICN #: _____ Date of Injury: _____

Medicaid/Medicare Advantage Plan #: _____ Date of Birth: _____

Persons/ Entities authorized to provide the information:
Any treating physicians or health care providers, my Employer, any Health Insurance Payers, the Centers for Medicare & Medicaid Services, MyMedicare.gov, Social Security Administration, MDLive, Inc., Medicaid, and the COB&R (including associated contractors).

Persons/ Entities authorized to receive, use, and disclose the information:

1. Franco Signor, LLC
   3647 Cortez Road West, Suite 100
   Bradenton, Florida 34210
2. Designated private Medicare Advantage Plan as contracted through Medicare (CMS)
3. Centers for Medicare & Medicaid Services (CMS)

Description of information:
1. All medical records, including, but not limited to, documents, reports, notes, bills, test results or x-rays.
2. Any information as ma y be requested by Franco Signor from any person/ entity authorized to provide the information, which, in Franco Signor's sole discretion, is required or necessary to accomplish the purpose of this Authorization.

Purpose of Authorization:
1. This Authorization for use or disclosure of information is at the request of the individual/ claimant.
2. To provide a full disclosure of any information to Franco Signor, LLC, to enable it to evaluate, determine, and prepare a recommended Medicare Set-Aside Arrangement, and to complete any other applicable and requested services, including Conditional Payments (Medicare Lien) Research, Final Lien Amount Demand and Lien Negotiation.
3. To designate Franco Signor, LLC as its representative to have the authority to communicate with CMS, the COB&R and associated contractors, and any private Medicare Advantage Plan or Medicare Advantage Organization (as specifically designated above) to obtain Conditional Payment information and to dispute or negotiate, on my behalf, any request for Conditional Payment Reimbursement related to the undersigned Medicare beneficiary.

I acknowledge and understand the following:
1. That if the person or entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations;
2. That my health care, payment of health care, treatment, enrollment, eligibility for benefits, or the amount Medicare pays for the health services will not be affected if I do not sign this authorization form;
3. That I have had the Workers' Compensation Medicare Set-Aside Arrangement need and process explained to me, and I approve of the contents of the submission.
4. That I may copy this Authorization after I sign it, and if I am unable to make a copy, I may request a copy from Franco Signor;
5. That this authorization expires upon approval of the Medicare Set-Aside Arrangement by CMS and completion of any other services;
6. That I may revoke this Authorization at any time by written notice to Franco Signor, LLC, but that any revocation shall have no effect on actions which have been taken by Franco Signor prior to receiving my revocation;
7. That any personal medical information that I authorize to disclose may be subject to re-disclosure and no longer protected by law;
8. That I have the right to refuse to sign this authorization.

Beneficiary Initials: _____

I have read and understand the contents of this Authorization and have had the opportunity to discuss same with counsel of my choice. The contents of this Authorization confirm, and are consistent with, my authority, instructions, or directions to Franco Signor, LLC, and I understand that by executing this Authorization, I am authorizing Franco Signor, LLC, to use and disclose, as permitted and outlined herein, certain nonpublic information.
IMPORTANT: Your signature below authorizes Franco Signor, on your behalf, to complete Provider and/or Clearinghouse HIPAA forms without the need to obtain your original signature, and thereby authorize Franco Signor to use a copy of your signature from this form.

_____ Date: _____
Signature of Claimant or Legal Representative

_____
Relationship to Claimant if Legal Representative

(Except for Legal Representatives acting in capacity as a parent to the claimant, a copy of the document giving the Legal Representative the authority to sign this Authorization must be attached.)
**In the case where a minor child is the claimant, the release MUST have the child's SS# on it, but signed by the Parent or Legal Guardian.*