Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
Medval, LLC	8860 Columbia 100 Parkway, Suite 308 ; Columbia, Maryland 21045

I want this information released because:

Medicare's interests in a potential insurance settlement pursuant to the Medicare Secondary Payer Act

(There may be a charge for releasing information.)

Please release the following information:

____ Social Security Number
____ Identifying information (includes date and place of birth, parents' names)
____ Monthly Social Security benefit amount
____ Monthly Supplemental Security Income payment amount
____ Information about benefits/payments I received from _____ to _____
____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
____ Medical records
____ Record(s) from my file (specify) _____
X Other (specify) Social Security entitlement status, date of SS entitlement or date of application if still pending, date of denial, date of appeal, status of appeal, basis for entitlement (disability or age), Medicare status, date of entitlement for Medicare A and B.

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____