Authorization for Use and Consent to Release Protected Health Information Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 C.F.R. §164.508)

I authorize _____ (Disclosing Party) to disclose and release my Protected Health Information (defined below) to Legacy Claim Solutions, its subsidiaries and/or its or their employees, agents, affiliates or representatives ("LCS"). I understand the signing of this document ("Consent to Release") is voluntary and shall have no effect on any benefits to which I may be entitled.

Name: _____ Date of Birth: _____

Member ID/Medicare ID#/SS#:_____ Date of Injury/Illness: _____

Protected Health Information to be Disclosed - This Consent to Release authorizes the release and use of information regarding healthcare claims and other information related to my injury and/or illness and the medical care performed or paid for by the lienholder, whether accessed online by websites containing such information or otherwise, including, but not limited to: my entire medical record, patient histories, office notes, diagnosis and procedural codes, lab/test results, radiology studies, films, referrals, consults, records sent to you by other health care providers, that could include data on certain conditions such as HIV/AIDS, mental health, and alcohol and substance abuse, billing records, payment history, insurance records, information describing enrollment status and/ or medical care performed or paid for by the healthcare lien/claim holder relating to the injury-related charges for the period beginning with the date of incident in any form including electronic ("Protected Health Information or PHI").

Person(s)/Entity Authorized to Receive and Use PHI - I authorize the disclosure and use of non-public PHI described above to Legacy Claim Solutions, its subsidiaries and/or its or their employees, agents, affiliates, or representatives at:

Legacy Claim Solutions
1106 Second Street, #473
Encinitas, CA 92024
Attn: Tom Matson

The entity described above is authorized to receive any and all information related to the above described claim from any healthcare lienholder, contract representative, and/or private plan administrator in order to pursue, negotiate and resolve any potential healthcare lien and/or subrogation right or interest ("Lien"). I understand that this disclosure of PHI by Disclosing Party may be re-disclosed by LCS (either or both "Disclosures") and as a result, may no longer be protected by federal or state law and I release LCS and Disclosing Party from any and all liability arising from Disclosures of my PHI.

Revocation Right - I have the right to revoke this Consent to Release authorization in writing at any time. I understand that any such revocation is not effective to the extent that any person or entity has already acted upon it in reliance. I understand that my treatment, payment, amount of payment, enrollment or benefit eligibility may not be conditioned upon signing of this Consent to Release or my disclosure of PHI.

Effective Period - If not previously revoked, this Consent to Release will expire two (2) years after all claims, if any, have been resolved, unless a different time period is listed below:

_____ _____ _____

Claimant/Applicant/Injured Party or Legally Authorized Rep Signature **Print Name** **Date**

(Legally Authorized Representative shall sign in representative capacity, print name and attach copy of legal document verifying legal authority as a representative (such as guardianship /conservatorship letters of authority, powers of attorney, etc.)

Confidentiality Statement - The collection of this information pursuant to this Consent to Release is authorized by Section 1862(b) of the Social Security Act (codified at 42 U.S.C 1395y(b)) (see also 42, C.F.R. 411.24) and may be used to identify and recover past conditional and mistaken Medicare primary payments as well as any such Medicaid payments in determining whether a no-fault, automobile, liability insurer, or any other person(s) or plan may be responsible for such payment. A photocopy, pdf or facsimile of this form shall be valid and given the same force and effect as the original.