CONSENT TO RELEASE

In compliance with the Federal Privacy Act of 1974 and the HIPAA Privacy Rule, in order for James E. Logan & Associates/Medivest to assist with the undersigned's workers' compensation, liability, or no-fault claim, the undersigned authorizes a representative of James E. Logan & Associates/Medivest to communicate with the Centers for Medicare & Medicaid Services (CMS) and their contractors, and the Social Security Administration, to obtain information about his/her benefits and Medicare conditional payments made relating to the injury, which occurred on the date listed below.

The undersigned also authorizes James E. Logan & Associates/Medivest to disclose his/her Social Security number to CMS, its agents and/or contractors, and/or the Social Security Administration.

Name of Entity:	***James E. Logan & Associates/Medivest***
Contact for above entity:	Debra J. Iacovacci or other authorized representative
Address:	27750 Middlebelt Road, Suite 100 Farmington Hills, MI 48334
Email:	diacovacci@logansettlements.com
Telephone:	(248) 865-3900

This Consent remains valid for a period of:

(X) One Year ( ) Two Years ( ) Other _____
(Provide a specific period of time)

I understand that I may revoke this "Consent to Release" at any time.
(Please contact James E. Logan & Associates to obtain contact information for revocations.)

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: _____ Date Signed: _____

Beneficiary Name: _____
(Please print exactly as shown on your Medicare card)

Medicare Number: _____
(The number on your Medicare card)

Social Security Number: _____

Date of Accident: _____