Form Approved
OMB No. 0938-0930

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION RELEASE FORM

WHO CAN USE THIS FORM?

People with Medicare who want 1-800-MEDICARE to be able to share their personal information with people they choose.

NOTE: By law, you must give 1-800-MEDICARE permission in writing before 1-800-MEDICARE can share any information with someone other than you. Find the full list of how 1-800-MEDICARE uses your information in the privacy notice within the Medicare & You handbook.

WHEN DO YOU USE THIS FORM?

- To add someone that 1-800-MEDICARE can share information with.
- To change or remove someone that 1-800-MEDICARE can share information with.
- To get information for someone who is deceased (if you legally have the right to that information because you're an Executor or have court documents giving you rights to that information.)

NOTE: If you change or remove someone, 1-800-MEDICARE can only apply that change to new requests. Medicare can't take back items we've already shared with others you approved.

WHERE TO SEND YOUR COMPLETED AUTHORIZATION FORM

After you complete and sign the authorization form, return it to:

1-800-MEDICARE
Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For faster service, you may submit this form online by logging in to your secure online **Medicare.gov** account.

FOR NEW YORK RESIDENTS WITH MEDICARE ONLY

The New York State Public Health Law protects the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV. Because of this law, **New York Residents must follow specific instructions for completing section 2. Instructions are located at the end of this form.**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB No. 0938-0930

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION RELEASE FORM

Use this form to tell 1-800-MEDICARE who can access your personal health information. Whether you choose to share your personal health information or not has no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for your health services.

INFORMATION ABOUT THE PERSON WITH MEDICARE

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. Name *(First, Middle, Last, Suffix)*

Robin W. Smith

Medicare Identification Number	**Date of Birth** *(mm/dd/yyyy)*
Medicare Identification Number	12/25/2025

Street Address

123 Main St

City	**State**	**Zip code**
San Francisco	CA	94106

2. Choose the information you want 1-800-MEDICARE to share.

2A: Check only one box

- [X] Limited Information *(go to question 2B)*
- [ ] Any Information *(go to question 3)*

2B: What kind of "limited information" do you want us to share? *(Check all that apply)*

I want to share limited personal health information about my:

- [X] Medicare eligibility
- [X] Medicare claims
- [X] Plan enrollment *(e.g. drug or MA Plan)*
- [X] Premium payments
- [X] Other *(Write any other information you want shared below. For example, payment information)*

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2C: FOR NEW YORK RESIDENTS ONLY

Please select **one** of the following options. If you're unsure, review the instructions at the end of this form.

☒ Include all information. This includes information about alcohol and drug abuse, mental health treatment, and HIV.

☐ **Don't** include information about alcohol and drug abuse, mental health treatment, and HIV.

3. How long can 1-800-MEDICARE use this authorization to share your personal health information? Check only one box. *(Subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):*

☒ Share my personal health information indefinitely.

☐ Share my personal health information for a specific period of time:

Beginning: 12/25/2025 *(mm/dd/yyyy)* and Ending: 12/25/2025 *(mm/dd/yyyy)*

4. Explain why you're giving 1-800-MEDICARE permission to share your information *(You may write "At my request"):*

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5. Enter the name of each person or organization that can get your personal health information from 1-800-MEDICARE. If you want to share your information with more than 2 people or organizations, list them on the back of this form. Be sure to include their name and address.

Person/Organization 1 Robin W. Smith		
Full Name 123 Main St		
Street Address San Francisco		
City 123 Main St, San Francisco CA, 94106	**State** 123 Main St, San Francisco CA, 94106	**Zip code** Robin W. Smith
Person/Organization 2 123 Main St		
Full Name San Francisco		
Street Address CA		
City 94106	**State** CA	**Zip code** 94106

6. **By signing this form, I authorize 1-800-MEDICARE to share my personal health information listed above to the person(s) or organization(s) I named on this form.** I understand that my personal health information may be shared by the person(s) or organization(s) and may no longer be protected by law.

Signature	**Telephone Number**	**Date** *(mm/dd/yyyy)*
	(555) 444-3333	

☒ Check here if you are signing as a personal representative and complete the form below.

Be sure to attach the appropriate documentation (like a Power of Attorney) if someone other than the person with Medicare signed above.

Personal Representative's Information

Full Name Robin W. Smith			
Street Address 123 Main St			
City San Francisco		**State** CA	**Zip code** 94106
Telephone Number (555) 444-3333	**Relationship to the person with Medicare**	Personal Representative Relationship to Medicare Holder	

7. **Send the completed, signed authorization form to:**

1-800-MEDICARE
Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

8. **Important:** You have the right to cancel (“revoke”) your authorization at any time. To cancel your authorization, send a written request to the address above. After we process the request, we’ll no longer share your personal health information (except for any information we already released based on your original permission).

STEP BY STEP INSTRUCTIONS FOR FILLING OUT THIS FORM

By law, Medicare must have your written permission (an "authorization") to use or give out your personal health information for any reason that isn't described in the privacy notice in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already released information based on your permission.

If you want someone to be able to call 1-800-MEDICARE on your behalf or you want us to share your personal health information with someone other than you, you need to let Medicare know in writing.

If you're requesting personal health information for a deceased person who had Medicare, please include a copy of the legal documentation that gives you the authority to request this information. (For example: Executor/ Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, explain your relationship to the person with Medicare.

Follow these instructions to complete your form. Be sure to complete all sections so we can process your form on time.

1. In section 1, enter the following information about the person with Medicare who's authorizing the release of their personal health information:
   - Name
   - Medicare number (enter the number exactly as it appears on the red, white, and blue Medicare card)
   - Date of birth
   - Address

2. In section 2A, check a box to tell us how much personal health information we're allowed to share. You can choose to let us share all of your personal health information, or only limited information. If you decide you only want us to share limited information, check 1 or more of the boxes in section 2B to indicate which types of information you're giving us permission to share (for example, Medicare eligibility).

   IMPORTANT: Special instructions for New York residents

   The New York State Public Health Law protects the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV. Because of this law, **New York Residents must follow these instructions for completing section 2:**

   - **Section 2A:** Check the box for Limited Information, even if you want to let us share any and all of your personal health information.
   - **Section 2B:** Check 1 or more of the boxes and include any other specific information you're giving us permission to share in the space provided. For example, you could write "payment information".
   - **Section 2C**: Check one of the boxes to tell us how much of your personal information we're allowed to share:
     - **If you give us permission to share all your information, check the box: "All information**, including information about alcohol and drug abuse, mental health treatment, and HIV".
     - **If you don't give us permission to share information about alcohol and drug abuse, mental health treatment, and HIV**, check the box: "Don't include information about alcohol and drug abuse, mental health treatment, and HIV".

3. In this section, check a box to tell us if you give us permission to share your personal health information indefinitely, or only for a specific period of time. If you only want us to share your information for a certain period of time, enter the start and stop dates for sharing your information.

4. Explain why you're giving us permission to share your personal health information.

5. Enter the name of each person or organization that can get your personal health information. You may list more than 1 person or organization.

   If you include an organization, you must also identify at least 1 person within that organization who can get your personal health information.

6. Sign and date the form, then enter your telephone number.

   If you're completing the form for someone with Medicare:

   - Sign and date the form, then enter their telephone number.
   - Check the box to indicate that you're signing the form as a personal representative.
   - Enter your address, phone number, and relationship to the person with Medicare.
   - Attach a copy of the paperwork that shows you can act for the person (for example, Power of Attorney).

7. Mail your completed, signed authorization form. **Make a copy of your signed authorization form for your records before you mail it.**

   1-800-MEDICARE
   Written Authorization Dept.
   PO Box 1270
   Lawrence, KS 66044

8. If you change your mind later and no longer want us to share your personal health information, write to the address shown in section 7 and tell us. Your letter will cancel your authorization form, and we'll no longer share your personal health information (except for any information we already released based on your original permission).

   If you have any questions or need help with this form, call us at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit **Medicare.gov/about-us/accessibility-nondiscrimination-notice** or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0930.

The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn.: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **DO NOT MAIL YOUR COMPLETED FORM TO THIS ADDRESS. If you do, we won't be able to process your form, and your request to release your personal health information will be significantly delayed.**