DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Medicare Hearings and Appeals

INDIVIDUAL APPELLANT'S CONSENT TO THIRD-PARTY FOR COPIES OF THE INDIVIDUAL APPELLANT'S RECORD(S)

I, _____, the appellant, hereby give consent to _____ to request and receive a copy of the following record(s) from the Office of Medicare Hearings and Appeals (OMHA), Department of Health and Human Services.

Please specify below in detail the record(s) to which this consent applies. Include the title of the record and the date it was sent/created. If you need more room please attach another sheet of paper.

Please check one:

☐ The third-party specified in this consent may receive an unedited copy of the record(s) specified above.

☐ The third-party specified in this consent should only receive a edited copy of the record(s) specified above.

I would like the following information removed:

Please check one:

☐ This consent is valid for the life of the appeal at the OMHA.

☐ This consent is only valid for the time it takes to process the record(s) specified above.

Please provide the information for the individual appellant if available:

Name		ALJ Appeal Number
Health Insurance Claim (HIC) Number	Social Security Number	Date of Birth

VERIFYING YOUR IDENTITY

In addition to completing this form, the individual appellant's consent must be notarized by an official notary public in order to verify the individual appellant and third-party's identity. Please have the following statement notarized:

I _____, the individual appellant, certify that I am in fact the individual I claim to be. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense under the Privacy Act subject to a $5,000 fine.

I _____, the third-party, certify that I am in fact the individual I claim to be. I understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense under the Privacy Act subject to a $5,000 fine.

Individual Appellant's Name		**NOTARY SEAL**
Individual Appellant's Signature	Date	
Third-Party's Name		
Third-Party's Signature	Date	
Notary Public's Name		
Notary Public's Signature	Date	**Notary's Expiration Date**

The OMHA will make every effort to deliver a copy of the requested records before the date of the hearing.

PRIVACY ACT STATEMENT

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(h)(I), and 1876 of Title XVIII). The information provided will be used to further document your appeal. The Social Security Number will be used to verify the identity of the individual appellant. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.