

Consent for the Release of Confidential Alcohol or Drug Treatment Information

Medicare is working with groups of doctors and medical providers participating in Accountable Care Organizations (ACOs). Under this program, Medicare shares information from claims submitted to Medicare to help your doctor(s) and health care team give you with the best possible care.

To protect your privacy, Medicare usually doesn't share information about alcohol or drug treatment with ACOs. However, having this information can help your doctor better coordinate your care. You can give Medicare permission to include alcohol or drug treatment records in the claims information Medicare shares with ACOs each month.

To give your permission for Medicare to share your alcohol or drug abuse treatment information with your primary care physician's Pioneer ACO, complete this form and return it to the address on page 2.

Medicare won't share your alcohol and drug abuse treatment information unless you complete, sign and return this form.

A. Your Rights

Medicare won't share any information with your primary care physician's Pioneer ACO about alcohol or drug abuse treatment without your permission. You can give Medicare permission to share this information with your primary care physician's Pioneer ACO by completing and returning this form. Your permission will take effect within 60 days.

Your permission to share this information will remain in effect until December 31, 2016, unless you notify us that you no longer want Medicare to share this information. You can ask Medicare to stop sharing your information at any time by completing the "Consent to Change Data Sharing Preference" form and submitting it to the address listed in Section D of this form.

At any time, you have the right to ask your primary care physician's Pioneer ACO to explain which health care providers working with Partners ACO will have access to your medical data and information.

I've read this whole section and understand my rights. I understand that by completing this form, I'm telling Medicare not to share my personal information with my primary care physician's Pioneer ACO.

Signature: _____

Full Name (printed): _____

Date: _____

B. Your Information

Full Name (printed): _____

Date of Birth: _____

Home Phone Number: _____

PCP: _____

