

Consent to Change Data Sharing Preference

To help give you the best possible care, Medicare shares certain Medicare claims information with your primary care provider's Pioneer ACO about the care their patients get. Having this information will help your doctor(s) and health care team give you the best possible care and treatment options. Your privacy is very important to us, and you control the use of your personal information.

Use this form ONLY if you already informed Medicare of your data sharing preferences by doing one of these things:

- You signed and mailed the "Authorization to Withhold Personal Health Information" form
- You signed and mailed the "Consent for the Release of Confidential Alcohol or Drug Abuse Treatment Information" form
- You called 1-800 MEDICARE (1-800-633-4227) TTY: 1-877-486-2048

If you're not sure whether you already informed Medicare of your data sharing preferences, call 1-800 MEDICARE (1-800-633-4227).

A. You Can Opt Out of Information Sharing at Any Time

You have the right to opt out of having your personal medical information shared with your primary care provider's Pioneer ACO at any time. Additionally, Medicare won't share any information with your primary care provider's Pioneer ACO about alcohol or drug abuse treatment unless you give Medicare written permission to share this information. You can change how Medicare shares your personal medical information at any time by completing this form and returning it to the address listed on page 2. Your preferences will take effect within 60 days of your request.

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

Signature: _____

Full Name (printed): _____

Date: _____

B. Your Information

Full Name (printed): _____

Date of Birth: _____

Home Phone Number: _____

PCP: _____

C. Do You Give Medicare Permission to Share Your Personal Medical Information?

Yes, please allow Medicare to share my individually identifiable health information with my primary care provider's Pioneer ACO, except for information relating to any alcohol or substance abuse treatment.

No, don't allow Medicare to share my individually identifiable health information with my primary care provider's Pioneer ACO, including any information relating to any alcohol or substance abuse treatment.

Signature of Patient

Print Name

Date: _____

Check here if the person completing and signing this document is serving in the capacity of a personal representative of the listed Medicare beneficiary. Please attach the appropriate documentation to demonstrate your legal authority to execute this document on behalf of the beneficiary (for example, Durable Medical Power of Attorney). This box should only be checked if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP):

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

D. How to Submit Your Form

Fill out, sign and return this form to the following address:

Partners HealthCare
115 Fourth Avenue
Needham, MA 02494

E. Questions?

You may call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.