Maine Community Accountable Care Organization

Date: ____________________

Declining to Share Personal Health Information

Please sign this form if you do **NOT** want Medicare to share your personal health information with the Maine Community Accountable Care Organization. Please note that even if you do not want to share your personal health information with the Maine Community Accountable Care Organization for use in coordinating your care, CMS will still need to use your information for some purposes, including certain financial calculations and determining the quality of care provided by our office and the Maine Community Accountable Care Organization. Also, as part of assessing the quality of care our office and the Maine Community Accountable Care Organization are providing, Medicare may share some of your personal health information with the Maine Community Accountable Care Organization.

You can also call 1-800 MEDICARE (1-800-633-4227) instead of completing this form. TTY users should call 1-877-486-2048.

Your decision not to share your personal health information with the Maine Community Accountable Care Organization will remain in effect until you tell us that you have changed your preference. You may change your decision not to share your personal information at any time. See the different ways you can submit your preferences on page 2 of this form. Your request will take effect in approximately 45 business days.

Your Information

Name (First and last name of the person with Medicare): ____

Physical Street Address: ____

City: ____________________________________ State: ______________ Zip Code: ________

Mailing Address (if different): ____

City: ____________________________________ State: ______________ Zip Code: ________

Instructions for Declining to Share Personal Health Information

❑ **No, please do not allow Medicare to share any of my personal health information with the Maine Community Accountable Care Organization.**

______________________________________ ______________________________________

Signature of Patient Print Name

Date: ____________________

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 <u>only</u> be checked if someone other than the Medicare beneficiary 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: ____________________________

How to Submit Your Preference

Fill out, sign and return this form to your provider's office in person, or via mail to the following address:

Maine Community Accountable Care Organization
PO Box 27773
Houston, TX 77227

OR

Call 1-800-MEDICARE at **1-800-633-4227** and say that you wish Medicare to stop sharing your personal information with the Maine Community Accountable Care Organization, or that you want to talk about ACOs.

Questions

If you have any questions, please contact 1-800-MEDICARE at **1-800-633-4227** and tell the operator you are asking about ACOs. TTY users should call 1-877-486-2048.