ASSOCIATES IN FAMILY MEDICINE, P.C.
Be heard. Be well.

Date: _____

Declining to Share Personal Health Information

Please sign this form if you do NOT want Medicare to share with Associates in Family Medicine, your personal health information related to care you have received from other doctors or healthcare providers.

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 to have Medicare not share your personal health information with [Name of CPC Practice] will remain in effect until you tell us that you have changed your preference. You may change your decision to have Medicare not share with [Name of Practice] your personal health information related to care you have received from other doctors or healthcare providers 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 my personal health information about care I have received from other doctors or healthcare providers with [Name of Practice**

_____ _____

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 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 [Name of Practice] in person, or via mail to the following address by [date]:

CPC Practice
Practice Address Line 1
Practice Address Line 2
City, State ZIP]

OR

Call 1-800-MEDICARE at **1-800-633-4227** and say that you want Medicare to stop sharing your personal health information about care you have received from other doctors or healthcare providers with [Name of Practice], or that you want to talk about the Comprehensive Primary Care Initiative.

Questions

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