Dean & St Mary's

Consent for the Release of Confidential Alcohol or Drug Treatment Information

If you have received such treatment, Medicare will only share information relating to your alcohol or drug abuse diagnosis, treatment, or referral for treatment with your doctor's Accountable Care Organization (ACO) with your written consent.

Please sign this form if you wish to allow Medicare to share information about your alcohol or drug diagnosis, treatment or referral for treatment with Dean Clinic & St. Mary's Hospital ACO, LLC, which your doctor participates in. Your decision to allow Medicare to share this information will remain in effect unless you change your preference. You may choose to withdraw your consent to share your alcohol or drug treatment information at any time. Your requested change will take place within 45 business days after your notification.

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 _____

Consent for Release

I, _____ (Name of Patient), authorize Medicare to disclose to Dean & St. Mary's all information regarding my past, present, and future treatment for alcohol, drug treatment, or substance abuse. The purpose of the disclosure of these records is to give my doctors and other health care providers involved in my care accurate and timely information about my medical history to allow the health care providers that treat me to coordinate my care.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may withdraw my consent at any time and my preference will be honored within 45 days of my request. If I do not change my preference to share this information, I understand that my information will continue to be shared with the ACO until their program participation ends.

Dean & St Mary's

_____ _____

Signature of Patient Date

_____

Print Name

☐ **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.**

Please Print the Personal Representative's Address (if you have checked the box above)

Street Address _____

City _____ State _____ Zip Code _____

Telephone Number of Personal Representative _____

Personal Representative's Relationship to the Beneficiary _____

How to Submit Your Form

To submit your consent to share information about your alcohol or drug diagnosis, treatment or referral for treatment with Dean & St. Mary's, please fill out, sign and return this form to your doctor's office (in person) or via mail to the following address:

Attn.: Decision Support/ACO
Dean Clinic – Corporate Office
1808 W. Beltline Hwy
Madison, WI 53713-9469

Questions?

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