

Accountable Care Organization (ACO) Consent

Help Us Improve Your Health Care Experience

One of the unique features of the ACO plan is how Medica works with your provider to coordinate your health care. Medica and your care system can enhance this experience by sharing member information with each other, ensuring that you're offered programs and services that can benefit you. To share your health information (including treatment from providers outside your care system), we need your permission. Please complete the form below and return it to us at the address on the reverse side of this form.

Request for Permission to Share Your Information

I authorize the release of my health record information (and that of my dependents age 11 and under) between Medica and the care systems for care coordination purposes.

Yes

No

Please circle the ACO product you've chosen below:

Fairview and North Memorial Vantage with Medica

Inspiration Health by HealthEast with Medica

Park Nicollet First with Medica

Ridgeview Community Network powered by Medica

Subscriber's Information

The subscriber is the person enrolled in the plan through his or her employer.

Subscriber's name (First and Last) *please print*: _____

Subscriber's date of birth: _____

Subscriber's email address: _____

Subscriber's signature: _____

Date: _____

(Your consent is valid for one year from the date you sign this form)

If you have family members age 12 or older who are also covered by your plan, please have them complete the information on the back of this form.

Continued on reverse

Dependents' Information

Dependents age 12 and older must provide their own consent by signing below. If you need additional space, please use another piece of paper to provide the requested information for each dependent.

Dependent #1

I authorize the release of my health record information Yes No

Dependent #1's name (First and Last) *please print*: _____

Dependent #1's date of birth: _____

Dependent #1's email address: _____

Dependent #1's signature: _____

Date: _____

Dependent #2

I authorize the release of my health record information Yes No

Dependent #2's name (First and Last) *please print*: _____

Dependent #2's date of birth: _____

Dependent #2's email address: _____

Dependent #2's signature: _____

Date: _____

Dependent #3

I authorize the release of my health record information Yes No

Dependent #3's name (First and Last) *please print*: _____

Dependent #3's date of birth: _____

Dependent #3's email address: _____

Dependent #3's signature: _____

Date: _____

Please note: Your consent is valid for one year from the date you sign this form.

Return to:

**Medica
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Minneapolis, MN 55440-9310**