



Department of Health

ANDREW M. CUOMO
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HOWARD A. ZUCKER, M.D., J.D.
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SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

Please print your name: _____ Date of Birth: _____

Form to Opt Out of sharing Medicaid Health Information in the New York State Delivery System Reform Incentive Payment (DSRIP) Program

To help you receive better health care as part of DSRIP, the New York State (NYS) Medicaid program would like to share information with your local Performing Provider System (PPS) about the care and treatment you have received. The PPS is made up of the doctors who already give you care. Having this information helps your doctor(s) and health care team give you better care. Your privacy is very important to us, and you control how your personal information is used.

As a Medicaid member, you have already given permission for New York State Medicaid, your providers and your health plan to access information to help you get care easier, to pay for your health care, and for health care operations. This form does not change any of that permission. So far, NYS has only shared your contact information with your local DSRIP PPS. **This form allows you to tell Medicaid that it cannot share your health information with your local DSRIP PPSs, and prevents the sharing of any further information, data and any of your personal Protected Health Information held by Medicaid with a PPS.** This is called “opting out”. This means you may not receive any of the services the PPS is developing in your area to provide improved care for Medicaid members.

You can opt out of the PPS sharing your Medicaid health information by

- calling the Medicaid Help Line: 1-855-329-8850
TTY Line: 1-800-662-1220
- completing this form and returning it by mail to the following address:
NYS Department of Health
PO BOX 11726
Albany, NY 12211

You can opt out at any time. When you opt out, NYS Medicaid will not share any of your personal Protected Health Information with your local PPS. If you do not want portions of your protected health information shared with the PPS, you must opt out.

However, NYS Medicaid, your health care providers and your health plan will continue to share your personal Protected Health Information as you agreed to upon joining NYS Medicaid and as allowed by New York State and federal laws.

If you wish to opt out of Medicaid sharing your health information with your local PPS, you should submit this request within 30 days to the Department of Health. It may take up to 60 days to process your request. If you want Medicaid to share your data with the PPS, you need do nothing. You do not need to mail this letter back.

I have read this whole section and understand my rights. I understand that by completing this form, I am telling the New York State Medicaid Program that I do not want Medicaid sharing my personal protected health information with the local Performing Provider System.

Signature of Medicaid member/parent/legal guardian

Today's Date:

Your Medicaid Number:

Your full phone number:

Si usted quisiera ver esta carta en español, por favor visite el siguiente sitio web:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/consumers.htm

**If you would like to view this letter in 18 point Font,
please visit the following website:**

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/consumers.htm