

Withdrawal of Consent for Participating Provider Organization

_____ (Name of Participating Provider Organization)

I have previously signed a Patient Consent Form allowing _____ to access my medical information through the Brooklyn Health Information Exchange (“BHIX”).

I understand that by withdrawing my Consent, _____ will no longer be able to routinely access medical information about me through BHIX.

If I sign this form as the Patient’s Legal Representative, I understand that all references in this form to “me” or “my” refer to the Patient.

1. The Withdrawal of Consent will not affect the exchange of medical information made while my Consent was in effect.
2. This Withdrawal of Consent only applies to _____ and is not applicable to any Consent given to another Participating Provider in BHIX.
3. It may take several days to process my Withdrawal of Consent.
4. No Participating Provider will deny me medical care and my insurance eligibility will not be affected based on my Withdrawal of Consent.
5. I understand that if I wish to reinstate Consent for _____ to routinely access my medical information through BHIX, I may do so by signing and completing a new Patient Consent Form and returning it to your Participating Provider at your next visit.
6. I understand that, unless I sign and complete a new Patient Consent Form at _____ indicating I Deny Consent, _____ will still be able to access medical information about me through BHIX in an emergency situation. I may ask _____ for a copy of the Patient Consent Form in order to Deny Consent when I submit this Withdrawal of Consent.
7. I understand I will get a copy of this form after I sign it.

Print Name of Patient

Patient’s Date of Birth

Signature of Patient or Patient’s Legal Representative

Date

Print Name of Patient’s Legal Representative (if applicable)

Relationship of Patient’s Legal Representative