

Withdrawal of Consent

I have previously signed a Patient Consent Form that granted access to my medical information through Healthcare Information Xchange of New York, doing business as Hixny. At this time, I no longer want _____ to have access to my medical information through Hixny.

1. This Withdrawal of Consent applies to _____ only. I understand that if I wish to withdraw my consent granting other Hixny organizations that participate in my treatment access to my medical information, I must do so by contacting these other Hixny Participants directly.
2. I understand that, by checking one of the boxes below, I am either denying _____ the right to access my medical information ***even in case of emergency***, or I am granting emergency access to my medical information:
 - ☐ **I wish my medical information to be available to in case of emergency**
 - ☐ **I do not wish my medical information to be available to even in case of emergency**
3. I understand that this Withdrawal of Consent will not affect or undo any exchange of my medical information that occurred while my original consent was in effect.
4. I understand that my withdrawal of consent for _____ does not affect any consent(s) that I may have previously given to other Hixny Participant(s). These will remain in effect until I specifically withdraw them by contacting these other Hixny Participants directly.
5. I understand that it may take several days to process this Withdrawal of Consent.
6. I understand that no Hixny Participant can deny me medical care as a result of this Withdrawal of Consent. I also understand that my health insurance eligibility cannot be affected this Withdrawal of Consent.

Print Name of Patient

Date of Birth

Signature of Patient/Patient's
Representative (if Patient unable to sign)

Date

Print Name of Patient's Representative

Relationship of Patient's Representative