Withdrawal of Consent
[Name of Organization]

I have previously signed a Patient Consent Form that granted [Name of Organization] access to my medical information through Healthcare Information Xchange of New York ("Hixny"). At this time, I no longer want [Name of Organization] to have access to my medical information through Hixny.

1. This Withdrawal of Consent applies to [Name of Organization] 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 the box below, I am denying [Name of Organization] the right to access my medical information:

   ☐ **I do not wish my medical information to be available to [Name of Organization]**

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 [Name of Organization] 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 by this Withdrawal of Consent.

______________________________ Print Name of Patient	______________________________ Patient's Date of Birth
______________________________ Signature of Patient/Patient's Representative (if patient is unable to sign)	______________________________ Date
______________________________ Print Name of Patient's Representative	______________________________ Relationship of Patient's Representative