
Printed Name of Patient

Entity Withdrawal Received By

Withdrawal of Consent to Participate in HEALTHeLINK Health Information Exchange

I have previously signed a Patient Consent form allowing access to my medical treatment and payment information (“Medical Information”) through the Western New York Clinical Information Exchange (“HEALTHeLINK”) and now want to withdraw that consent. 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.

By withdrawing my Consent, I understand that:

1. Health care providers and health insurers that I am enrolled with will no longer be able to access Medical Information about me through HEALTHeLINK, except in an emergency.
2. The Withdrawal of Consent will not affect the exchange of my Medical Information made while my Consent was in effect.
3. No HEALTHeLINK participating provider will deny me medical care and my insurance eligibility will not be affected based on my Withdrawal of Consent.
4. If I wish to reinstate Consent, I may do so by signing and completing a new Patient Consent form and returning it to a participating provider.
5. Withdrawing my consent does not prevent my health care providers from submitting claims to my health insurer for reimbursement for services rendered to me.
6. I understand that I will get a copy of this form after I sign it.

Patient’s Date of Birth

Signature of Patient or Patient’s Legal Representative

Date of Signature

Address/City/State/Zip Code of Patient

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

Authority to sign on behalf of patient
(e.g., health care agent, guardian, parent)