



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 HEALTHeLINK Participants to access my electronic health records 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. I have two options for denying consent

NO **I DENY CONSENT for all Participants to access** my electronic health information through HEALTHeLINK for any **EXCEPT** Purpose, *EXCEPT in a medical emergency.* By checking this box you agree, “No, none of the Participants may be given access to my medical records through HEALTHeLINK unless it is a medical emergency.”

NO **I DENY CONSENT for all Participants to access** my electronic health information through HEALTHeLINK for any **NEVER** purpose, *INCLUDING in a medical emergency.*

- 2. Health care providers and health insurers that I am enrolled with will no longer be able to access health information about me through HEALTHeLINK, except in an emergency unless I choose the NO NEVER option above.
- 3. The Withdrawal of Consent will not affect the exchange of my health information made while my Consent was in effect.
- 4. No HEALTHeLINK participating provider will deny me medical care and my insurance eligibility will not be affected based on my Withdrawal of Consent.
- 5. 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 or payer.
- 6. Withdrawing my consent does not prevent my health care providers from submitting claims to my health insurer for reimbursement for services rendered to me.
- 7. 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)