

INTERBORO RHIO WITHDRAWAL OF CONSENT FORM

PATIENT INFORMATION	<i>Please print clearly in English and complete all fields</i>		
Patient Name (Include First, Middle and Last Name)	Patient's Date of Birth	Gender	
<i>Current Patient Address</i>			
Street:	City:	State:	Zip Code:
<i>Previous Patient Address</i>			
Street:	City:	State:	Zip Code:
Phone Number	Email Address		

1. You previously signed an "Interboro RHIO Consent Form" authorizing a Healthcare Provider ("HP") to access your health information through Interboro RHIO. You wish to withdraw (cancel) that consent.
2. The withdrawal of consent process will not be completed until this Withdrawal of Consent form is recorded in the Interboro RHIO system. If there are any questions about this Withdrawal of Consent Form, a member of the Interboro RHIO staff will be in touch with you.
3. By signing this Withdrawal of Consent Form, you are DENYING CONSENT for the following Healthcare Provider(s) to access your health information through the Interboro RHIO for any purpose, even in a medical emergency:

HEALTHCARE PROVIDER INFORMATION	<i>Please print clearly in English and complete all fields</i>	
Name of Healthcare Provider Organization(s) NO LONGER authorized to receive YOUR health-related information through Interboro RHIO <i>(For example, the hospital name or the practice name)</i>		
Address of Healthcare Provider Organization		

** To withdraw consent for ALL healthcare providers participating in the Interboro RHIO, indicate "ALL" in the above boxes*

4. Interboro RHIO consents apply to an entire organization. By signing this Withdrawal of Consent Form, you are DENYING CONSENT for all providers who serve on the above listed HP's medical staff and staff members to access your health information through the Interboro RHIO for any purpose, even in a medical emergency.
5. This Withdrawal of Consent Form only applies to the above listed HP (unless you indicated 'ALL') and is not applicable to any Consent given to another Participating Provider in the Interboro RHIO.
6. The above listed HP may have accessed your health information through the Interboro RHIO while your consent is in effect and may have copied or included your information in their medical records. Although you have decided to withdraw your consent, they are not required to return this information or remove it from their records.

I wish to change the consent status on file for the above listed HP and DENY CONSENT for such HP to access my electronic health information through the Interboro RHIO for any purpose, even in a medical emergency.

Signature of Patient or Patient's Legal Representative

Date

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

Relationship of Legal Representative to Patient (if applicable)

RETURN INSTRUCTIONS: Please print, complete, and return this form to Interboro RHIO by either:

FAX: 646-998-8060 | **MAIL:** Interboro RHIO, PO Box 800038, Elmhurst, NY 11380