NYC | P.O. Box 800038, Elmhurst, NY 11380
79-01 Broadway, Elmhurst, NY 11373
Tel: 718-334-5844
Long Island | Flowerfield Industrial Park, Building 7,
Suite 44, St. James, NY 11780
Tel: 631-638-4000
www.nycig.org

Denial of Consent for All Participants

I understand that by signing this form, I am DENYING CONSENT for ALL Healthcare Providers, Payors and Insurance Providers, and all providers who serve on their staff, to access my health information through NY Care Information Gateway for any purpose, *even in a medical emergency*.

By withdrawing my consent, I understand that:

1. Healthcare Providers, Payors or Insurance Providers that I may have previously granted my consent to may have accessed my health information while my original consent was in effect, and may have copied or included this information in their records. Although I have decided to withdraw my consent, these Healthcare Providers, Payors or Insurance Providers are not required to return this information or remove the information from their records.

2. This Denial of Consent applies to ALL Healthcare Providers, Payors and Insurance Providers who access information through NY Care Information Gateway.

3. It may take several days to process this Denial of Consent.

4. I understand that, if I sign this denial of consent, it will remain in effect until I withdraw it. This means that I will not be able to authorize any Healthcare Provider, Payor or Insurance Provider to access my health information through NY Care Information Gateway while this denial of consent is in effect. If I wish to withdraw this denial of consent, I may do so at any time by contacting NY Care Information Gateway at info@nycig.org or 718-334-5844 and advising NY Care Information Gateway that I want to rescind my Denial of Consent for All Participants.

5. No NY Care Information Gateway Participant may deny me medical treatment based on this Denial of Consent.

Print Full Name of Patient _____ Patient's Date of Birth _____

Patient's Address/ City/ State/ Zip _____ Phone/ Email _____

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) _____

NOTARY PUBLIC

This document was signed before me on this ____ day of _____ 20____.

In _____County in the state of _____.

_____ _____

Printed Name of Notary *Notary Signature*

My commission expires: _____ (*Seal*)

RETURN INSTRUCTIONS: Please print, complete, & return this form by either:

FAX: 646-998-8060 | **MAIL:** NY Care Information Gateway, PO Box 800038, Elmhurst, NY 11380