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

English

Withdrawal of Consent

Name of Healthcare Provider (from which you are withdrawing consent): ______________________________

I have previously signed an "NY Care Information Gateway Consent Form" authorizing the above Healthcare Provider ("HP") to access my health information through NY Care Information Gateway.

I understand that by signing this form, I am DENYING CONSENT for the above HP, and all providers who serve on the above HP's medical staff and staff members, to access my health information through the NY Care Information Gateway for any purpose, *even in a medical emergency*.

By withdrawing my consent, I understand that:

1. The above HP may have accessed my health information while my original consent was in effect, and may have copied or included this information in their medical records. Although you have decided to withdraw your consent, the above HP is not required to return this information or remove the information from its records.
2. This Withdrawal of Consent applies to the above listed HP and does not affect consent(s) that I may have previously given other NY Care Information Gateway Participant(s).
3. It may take several days to process this Withdrawal of Consent.
4. If I wish to reinstate consent, I may do so at any time by signing and completing a new NY Care Information Gateway Consent form and returning it to the above HP.
5. No NY Care Information Gateway Participant may deny me medical treatment based on this Withdrawal 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)

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