ALLIANCE for Better Health

Hixny®

Withdrawal of Consent

Alliance for Better Health Care, LLC, a Performing Provider System

I have previously signed a Patient Consent Form that granted Alliance for Better Health Care, LLC, a Performing Provider System access to my medical information through Healthcare Information Xchange of New York ("Hixny"). At this time, I no longer want Alliance for Better Health Care, LLC, a Performing Provider System to have access to my medical information through Hixny.

1. This Withdrawal of Consent applies to Alliance for Better Health Care, LLC, a Performing Provider System only. I understand that if I wish to withdraw my consent granting other Hixny organizations that participate in my treatment access to my medical information, I must do so by contacting these other Hixny Participants directly.

2. I understand that, by checking one of the boxes below, I am either denying Alliance for Better Health Care, LLC, a Performing Provider System the right to access my medical information ***even in case of emergency,*** or I am granting emergency access to my medical information:

   ☐ **I do not wish my medical information to be available to Alliance for Better Health Care, LLC, a Performing Provider System, even in the case of an emergency.**

3. I understand that this Withdrawal of Consent will not affect or undo any exchange of my medical information that occurred while my original consent was in effect.

4. I understand that my withdrawal of consent for Alliance for Better Health Care, LLC, a Performing Provider System does not affect any consent(s) that I may have previously given to other Hixny Participant(s). These will remain in effect until I specifically withdraw them by contacting these other Hixny Participants directly.

5. I understand that it may take several days to process this Withdrawal of Consent.

6. I understand that no Hixny Participant can deny me medical care as a result of this Withdrawal of Consent. I also understand that my health insurance eligibility cannot be affected this Withdrawal of Consent.

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Print Name of Patient	Patient's Date of Birth
Signature of Patient/Patient's Representative (if patient is unable to sign)	Date

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Print Name of Patient's Representative

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Relationship of Patient's Representative