E-Health Network of Long Island
RHIO Revocation of Consent Form

e-health network of long island
www.eHealthNetworkLI.org
Flowerfield Industrial Park, Building 7, Suite 44
Saint James, NY 11780-1502

Patient Name	Date of Birth	Gender
Patient Address Street: City: State: Zip Code:		

1. Revocation of Consent. I previously authorized the release of my health information through e-Health Network of Long Island by signing a Consent Form. I have changed my mind and would like to revoke (cancel) my consent at this time. By signing this *Revocation of Consent Form*, I am hereby revoking my authorization for any of my health information to be released, accessed or shared through e-Health Network of Long Island, even in an emergency or unanticipated health event.

2. Effective Date of Revocation. This revocation of my consent will become effective when it is received by e-Health Network of Long Island and recorded in the e-Health Network of Long Island health information exchange system. This revocation of my consent will not affect disclosures or access to my health information while my authorization was in effect.

3. Voluntary Participation. I understand that I participated in e-Health Network of Long Island voluntarily and my revocation of consent means I no longer want to participate in e-Health Network of Long Island. I am signing this Revocation voluntarily.

4. Effect of Revocation. I understand that because I will not be participating in e-Health Network of Long Island, my health information will not be released by e-Health Network of Long Island to any hospital, physician or other health care provider even if I have an emergency medical condition (e.g., I am unconscious following a car accident and taken by ambulance to a hospital emergency room).

5. Authorized Representative.

Print name of Authorized Representative:_____

Authority to sign on behalf of patient (e.g., health care power of attorney, guardian, parent of minor):_____

All items on this form have been completed and my questions about this form have been answered. I hereby revoke my consent and authorization to participate in e-Health Network of Long Island.

_____ _____ Date: _____

Signature of Patient or Authorized Representative* | Health Care Provider/Facility

_____ Date: _____

Notary Public | Date of Expiration of Commission

Please complete and sign this form and mail or hand-deliver the original form to:

e-Health Network of Long Island
Flowerfield Industrial Park, Building 7, Suite 44
Saint James, NY 11780-1502

Facsimiles and copies will not be accepted.

* If the Patient or Authorized Representative does not sign this *Revocation of Consent Form* at a health care provider's facility or office, which has authenticated the identity of the Patient or Authorized Representative, then the signature of the Patient or Authorized Representative must be notarized.