ST. JOSEPH'S CARE GROUP

WITHDRAWAL OF CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

Place Patient Label with Barcode Here

I, _____, wish to withdraw my consent to any further use or disclosure by **ST. JOSEPH'S CARE GROUP** of my personal health information for:

_____

_____

_____

I wish to place the following conditions on any further use or disclosure of my personal health information:

_____

_____

_____

(Please specify conditions)

This withdrawal of consent does not have retroactive effect nor does it affect the uses and disclosures of personal health information collected by **ST. JOSEPH'S CARE GROUP** where the uses and disclosure are permitted or required by law without consent.

Name: _____

Address: _____

Hone Phone #: _____ Work Phone #: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

SCONWITHDRAW