WITHDRAWAL OF CONSENT FORM

***Withdrawal of Consent***

I, , wish to withdraw my consent to any further use of disclosure by *NP med inc.* of my personal health information for: (Please check all that apply)

* Do not let anyone view my personal health information
* Regional health information repositories
* Teaching outside NP med inc.
* Compiling statistics (other than as required by law)

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

(Please specify condition)

This withdrawal of consent does not have retroactive effect nor does it affect the uses and disclosures of personal health information collected by *NP med inc.* where the uses and disclosures are permitted or required by law without consent.

Name: Health Card #: Date of Birth:

Address:

Tel. Home: Tel Work: Signature: Date: