CAMBRIDGE MEMORIAL HOSPITAL
700 Coronation Blvd.,
Cambridge, ON N1R 3G2
519-621-2330

Withdrawal or Withhold Consent for Collection, Use or Disclosure of Personal Health Information

I _____ (name) am withdrawing or withholding my consent to any further use or disclosure by Cambridge Memorial Hospital of my personal health information, as indicated below:

_____

_____

_____

(Description of Personal Health Information)

to: _____

_____

(Name and Address of person/agency requesting information)

from the records of _____

(Name of Patient) (Date of Birth)

Mailing Address of Patient: _____

_____

In the event of a medical emergency, healthcare providers may access my personal health information. Cambridge Memorial Hospital will use or disclose personal health information collected that is required by law.

Date: _____

Witness: _____ Signed by: _____

(Patient or Substitute Decision Maker)

_____

(Relationship to Patient)

❒ Copy to Chief Privacy Officer (ext 2507) ❒ Copy on chart

_____

(Date of appointment with Chief Privacy Officer)