Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

Withdrawl of Consent

I, _____ , wish to withdraw my consent to any further use or disclosure by **Mackenzie Health** of my personal health information for: (please check all that apply)

- ☐ Conducting patient satisfaction surveys
- ☐ Teaching outside the **Mackenzie Health**
- ☐ Compiling statistics (other than as required by law)
- ☐ Fundraising

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

_____

_____

_____

_____

(Please specify conditions)

This withdrawl of consent does not have retroactive effect nor does it affect the uses and disclosures of personal health information collected by **Mackenzie Health** where the use and disclosures are permitted or required by law without consent.

Name: _____

Address: _____

Tel. Home: _____ Tel. Work: _____

Signature: _____ Date: _____

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(10/04)

Please add to the Medical Records
If no Medical Records, Please send to Medical Records