



## Withdrawal of Consent

I, \_\_\_\_\_, wish to withdraw my consent to any further use or disclosure by Runnymede Healthcare Centre of my personal health information for:

\_\_\_\_\_  
(briefly state purpose(s))

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Please specify condition(s))

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

Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_

Self \_\_\_\_\_ or Substitute Decision Maker \_\_\_\_\_ Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_ Date Signed: \_\_\_\_\_