WITHDRAWAL OF CONSENT

Patient Name:

Date of Birth:

Health Card Number:

Address:

Phone Number:

I wish to withdraw my consent to any further use or disclosure by the Nipigon District Memorial Hospital of my personal health information for the purposes of:

_____
_____
_____
_____
_____

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

_____ _____
Patient Signature Date

_____ _____
Witness' Signature Witness Name (please print)

January 2026