CONSENT WITHDRAWAL REQUEST FORM

Please note that the consent withdrawal request form can only be signed by the patient who wishes to withdraw their consent. By submitting this request, you as the patient understands that this practice will no longer be able to share any personal medical information with any of your other providers.

Patient Name: _____
Patient Surname: _____
Patient ID Number: _____
Medical Aid: _____
Membership No: _____ Dep Code: _____

Reason for Withdrawal:
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Consent:

I _____ (Full name and Surname) hereby withdraw my consent for the medical practice of Dr Jocelyn Hellig to share my medical and clinical information related to any of my consultations, results, ICD-10 codes and any subsequent discussions regarding my previous, current or further treatment with any other providers.
I understand that by signing this consent form, I am indemnifying the practice of Dr Jocelyn Hellig from any consequences that may follow as a result of my withdrawal, such as the delay or refusal to share any personal information with providers who might request this directly or indirectly from the practice. I also acknowledge that such a delay may come at a time when there may or may not be a life threatening situation.

_____	_____	_____
Signature	Place	Date