

PSYCKES Withdrawal of Consent Form

You previously signed a PSYCKES Consent form allowing your provider to obtain access to your Medicaid medical records electronically through PSYCKES and now want to withdraw that consent. This form may be filled out now or at a later date.

By withdrawing Consent, you understand that:

1. Health care providers and health insurers that you are enrolled with will no longer be able to access Medical Information about you through PSYCKES, except in an emergency or if another exception to the State and federal confidentiality laws and regulations applies. For example, if the Medicaid program has a quality concern about your healthcare, then under federal and state regulations your provider may be given access to your data to address the quality concern.
2. Your provider is not completely barred from accessing your medical information in any way. It may still be able to obtain necessary information directly from another provider for treatment purposes under state and federal laws and regulations.
3. The Withdrawal of Consent will not affect the exchange of your Medical Information made while your Consent was in effect.
4. No PSYCKES participating provider will deny you medical care and your insurance eligibility will not be affected based on your Withdrawal of Consent.
5. If you wish to reinstate Consent, you may do so by signing and completing a new PSYCKES Consent form and returning it to a participating provider.
6. Withdrawing your consent does not prevent your health care providers from submitting claims to your health insurer for reimbursement for services rendered to you.
7. You understand that you will get a copy of this form after you sign it.

Print Name of Patient:	Date of Birth of Patient:
Signature of Patient or Patient's Legal Representative:	Date:
Print name of Legal Representative (if applicable):	Relationship of Legal Representative to Patient (if applicable):
Signature of Witness:	Print name of Witness: