***MY HEALTH GPS***

**WITHDRAWAL OF CONSENT FORM**

**TO BE COMPLETED BY *MY HEALTH GPS* BENEFICIARIES AND PROVIDERS**

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| Name of Beneficiary: | Date of Birth: | Medicaid Number:  |
| Assigned *My Health GPS* Entity: | Managed Care Organization (MCO) if applicable: |

**Beneficiary**  *(Please Initial)*

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| When you do not want to participate in the *My Health GPS* program any longer, you need to know that: |
|  | Any *My Health GPS* Consent Forms that you signed in the past are no longer valid. |
|  | Your health information will be kept by providers who already have your information. They do not have to give it back to you or delete it. |
|  | Your personal health information will still be protected under DC and Federal laws and rules. Your health care providers who currently have your health information must obey these laws. |

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| --- | --- | --- | --- | --- |
| **Signature of Beneficiary or Legal Guardian (if applicable)** |  | **If Legal Guardian’s Signature, print name** |  | **Date Signed** |

**MY HEALTH GPS PROVIDER**

[ ]  I discussed the *My Health GPS* program with the Beneficiary. The benefits were explained; however, he/she decided to end their participation in My Health GPS. **By telephone** [ ]

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| **Signature of the *My Health GPS* Provider:** |  | **Name of *My Health GPS* Care Provider:** |  | **Date Signed** |

**FOR DHCF USE ONLY**

|  |  |  |
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| Date Form Received:  | Effective Date of Withdrawal: | Date Beneficiary Notified: |

**Please submit completed form by secure email to** myhgps@dc.gov**.**