



Do Not Contact Form

Patient's Name: _____
Last First Middle

Home Address: _____

Home Phone: _____ **E-mail:** _____

Date of Request: _____

I no longer wish to receive the following materials from Albert Einstein Healthcare Network (check the appropriate boxes).

Fundraising and Educational Materials

Marketing and Education Materials

Other:

I understand that Einstein will make reasonable efforts to accommodate this request.

Signature of Patient (or Personal Representative) **Date**

Printed Name of Personal Representative **Date**

Relationship to Patient

Instructions to Patient (or Personal Representative):

1. Please complete and sign this form.

2. Send this completed form by:

Mail: Albert Einstein Healthcare Network, Privacy Office, Sheerr Building, 5501 Old York Road, Philadelphia, PA 19141

Fax: 215-456-7339

E-mail: privacy@einstein.edu

For Internal Use Only:

1. This form was received/completed on _____.

2. On _____ this form was forwarded to:

Einstein Development Department

Einstein Corporate Marketing and Communications Department

Other: _____