(PLACE PATIENT ID LABEL HERE)

(ALL ENTRIES MUST HAVE DATE & TIME)

Einstein Healthcare Network

Do Not Contact Form

Do Not Contact

Patient's Name: _____ Date of Birth: _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____Work Phone: _____

E-Mail: _____Date of Request: _____

I no longer wish to receive the following materials from 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 Authorized Representative) **Date** **Time**

_____ _____

Printed Name of Personal Representative **Date** **Time**

_____

Relationship to Patient

Instructions to Patient (or Authorized Representative):

1. Please complete and sign this form.
2. Send this completed form by:
   Mail: Einstein Healthcare Network, **Fundraising Office**, 5501 Old York Road, Philadelphia, PA. 19141 Phone: 215-456-7200
   Mail: Einstein Healthcare Network, **Marketing Office,** 101 E. Olney Avenue, Suite 503 Philadelphia, PA. 19120
   Phone: 1-800-EINSTEIN

For Internal Use Only:

1. This form was received/completed on: _____

2. On: _____ this form was forwarded to:

- ☐ Einstein Development Department
- ☐ Einstein Marketing Department
- ☐ Other: _____

This form was forwarded by: _____