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: _____________________________________________________________________________________________