Opt Out Form

Opting out of the Doylestown Clinical Network (DCN)

I do not wish to share my clinical information on the DCN. Please opt me out of the DCN Electronic Health Record program.

First Name: _____ Middle Init: ___ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone – Home: (____)_____-_____ Mobile: (____)_____-_____ Work: (____)_____-_____

I understand that I am opting out of the DCN program and no further health information about me will be shared on the DCN.

Signature: _____ Date: ____ /_____ /_____

If you are a parent of guardian wishing to opt your child out of the program, or the legal guardian of a participating patient who is not legally competent to sign:

Signature of guardian: _____ Date: ____ /_____ /_____

Guardian First Name: _____ Middle Init: ___ Last Name: _____

Guardian Relationship to participating patient: _____

Please tell us why you have chosen to opt out of the DCN program.

_____

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May we contact you for future evaluation purposes? Yes _____ No _____