# ***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: _____Apt#:_____

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 or 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, __ Surname_____

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 ___