



450 Clarkson Ave.
Brooklyn, NY 11203

FUNDRAISING: OPT OUT FORM

We have sent you materials to raise funds for University Physicians of Brooklyn, Inc. If you do not wish to receive fundraising communications in the future, please complete this form and return it to the address documented above. We will make every effort to ensure that you do not receive any such future communications.

Patient Name: _____
Last Name First Name MI

Address: _____ Telephone: _____
_____ (daytime)
_____ (evening)

1. Do you want to stop receiving ALL fundraising materials?

☐ Yes

☐ No; please describe what type of materials you do not want to receive:

2. What is the title of the fundraising material we sent you? (Optional)

3. Is there a reason that you do not want to receive future fundraising communications? (Optional)

Print Name of Patient/ Personal Representative Signature of Patient/ Personal Representative

Description of Personal Representative's Authority

Date