



FUNDRAISING: OPT OUT DESIGNATION FORM

The following individual has elected to opt-out of SUNY Downstate fundraising activities

Patient Name: _____
Last Name First Name MI

Address: _____ Opt-Out Method Utilized:
_____ Phone _____ Email
_____ Other

1. Stop receiving ALL fundraising materials?

Yes
 No; please describe what type of materials patient does not want to receive:

2. Title of the fundraising material sent by Department? (Optional)

3. Any reason that patient elects to opt-out of receiving future fundraising communications? (Optional)

A. If form is being completed by the patient on date of visit/ admission, complete this section:

_____	_____
Patient Signature	Date

B. If form is being completed by SUNY Downstate staff member upon receipt of patient notification of opt out preference, complete this section:

_____	_____	_____
Name of SUNY Downstate Staff Member	Department	Extension

Date of Notification by Patient		