Date: _____

Consent to Change Personal Health Information Preference Consents Previously Signed.

The use of this form allows you to opt out of the following previously consented to

Use this form if you want to change your previous decision and opt out of the following (check all that apply)

- ○ Telemedicine
- ○ Electronic Health Exchange opt out entirely
- ○ Electronic Health Exchange opt out of Sensitive PHI information relating to any treatment that I may have received for alcohol or drug treatment.

To Submit Your Updated Preference

Fill out, sign and return this form to your provider's office in person, or email the completed form to contact@docsofct.com

Patient

SIGNATURE:

_____ DATE: _____

NAME:

_____

Parent or Guardian Signature (if patient is a minor)

SIGNATURE:

_____ DATE: _____

NAME:

_____

For Healow/Patient Portal, Text Messages, and marketing surveys, please follow the instructions listed to opt out of receiving notifications through those direct platforms. If you have any questions please contact DOCS Medical Inc. Administration Directors at 203-874-3682 or by e-mailing contact@DOCSofct.com