



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](mailto:contact@docsofct.com)

Patient

SIGNATURE:

\_\_\_\_\_ DATE: \_\_\_\_\_

NAME:

\_\_\_\_\_

Parent or Guardian Signature (if patient is a minor)

SIGNATURE:

\_\_\_\_\_ DATE: \_\_\_\_\_

NAME:

\_\_\_\_\_

For 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 Bristol Primary Care LLC Administration Directors at 860-261-5217 or by e-mailing [bristolprimarycare@gmail.com](mailto:bristolprimarycare@gmail.com)