



## Opt Out Form

We understand that you receive a great deal of information through the mail. It is our goal to make sure the correspondence you receive from Care Partners is what you and your family members desire.

If you prefer not to participate in the bereavement program and/or receive future mailings from Care Partners please complete and return this form to us at:

Care Partners  
Attn: Director of Bereavement Services  
1600 NW Compton Dr., Ste. 210  
Hillsboro, OR 97006

You may also submit your choice online at <http://carepartnersor.org/bereavement-support-program/opt-out/>

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

City

State

ZIP

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Name of Hospice Patient:** \_\_\_\_\_

I choose to opt out of Care Partners Bereavement Program (includes mailings and periodic phone calls)

I choose to opt out of **ALL** Care Partners communication and mailings (includes bereavement mailings, program surveys, newsletters and events)

**Comments:** \_\_\_\_\_

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