

**PLEASE FAX
THIS FORM TO
1-800-313-9764**

Fax Referral Form

Please Complete:

Name, title: _____
Organization: _____
Address: _____
City: _____ Prov.: _____ Postal code: _____
Phone: _____
Email: _____

Client Information:

Subscriber Name: _____
Subscriber Address: _____
City: _____ Prov.: _____ Postal code: _____
Phone: _____
Contact Person: *(If Patient/Client is not the primary contact)*
Name: _____ Phone Number: _____
Additional Notes: _____

Special Instructions: _____

For any questions please call **1-800-543-3546** to speak to a Sales Representative.

The purpose of Lifeline has been explained to me. I give my permission for the Agency named above to give my name and contact information to Philips Lifeline and its representatives so that a Lifeline representative may contact me, exclusively for the purpose of further explaining the product and related services. I do not have to accept the Lifeline service if I do not want it.

Your Signature: _____ Subscriber/Client Signature: _____ Date: _____

I have received verbal approval from the Subscriber/client to forward this information to Philips Lifeline.

CONSENT AND PRIVACY NOTICE: By submitting this form you acknowledge that you have obtained consent from the prospective subscriber named on this form to release their personal information to Philips Lifeline and that the information will be used to contact the prospective subscriber for the purposes of further explaining Lifeline's products and services. There is no obligation to accept any products or services.

CONFIDENTIALITY NOTICE: The information in this facsimile is for the sole use of the intended recipients and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender listed above.