

**PERMISSION FOR THE ELEANOR M. LUSE CENTER TO CORRESPOND BY EMAIL**

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I \_\_\_\_\_ give my permission for the Eleanor M. Luse Center to communicate with me by email for the following items:

\_\_\_\_\_ Appointment Dates and Times

\_\_\_\_\_ Insurance Information

\_\_\_\_\_ Treatment Information

\_\_\_\_\_ Other: (Explain)

Email Address: \_\_\_\_\_

I understand that email transmissions are never 100% secure. The risks include, but are not limited to, sending information to an incorrect email address; unauthorized access to the email account that has either sent or received the email ; unauthorized forwarding, printing, copying or otherwise sharing by individuals who receive the email; and interception of email while in transit. The same risks apply whether you are the sender or the recipient of the email containing PHI.

I understand these risks and still wish to have the Eleanor M. Luse Center communicate with me via email.

\_\_\_\_\_  
Signature (Client/Parent/Guardian)

\_\_\_\_\_  
Date