



E-mail Consent

I _____ authorize Southwest Pain Group to communicate via e-mail at the following e-mail address:

regarding my patient care. I authenticate all communications between Southwest Pain Group and the above e-mail address are from me. I approve all e-mail responses from Southwest Pain Group and grant full disclosure of information to the above e-mail address. I understand and acknowledge that communications over the internet are not secure, and that there is potential risk for compromise of personal and medical information during internet exchanges. I hereby release Southwest Pain Group from all responsibility related to exchange of personal and medical information via unsecured internet pathways.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

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Suite 320
Dallas, Texas 75231

9301 N. Central Expwy.,
Suite 200
Dallas, Texas 75231

4708 Alliance Blvd.
Suite 850
Plano, Texas 75093