



## IOWA MONITORING PROGRAM for Pharmacy Professionals

### Email Authorization

I authorize the Iowa Monitoring Program for Pharmacy Professionals (IMP3) to utilize the following email address to send me communication regarding my IMP3 participation.

Please clearly print email address: \_\_\_\_\_

- 1) I understand that the use of email is for my convenience and that I am not obligated to communicate via email with IMP3.
- 2) I understand the inherent unsecured nature of email and therefore accept the risks of using email.
- 3) I understand that I am responsible for informing IMP3 of any changes to my email address.
- 4) I am aware that email messages do not substitute for check-in calls as required by my IMP3 Initial Agreement and/or my Health Contract.
- 5) I understand that I may rescind email consent at any time upon written and signed notification to IMP3.

Name (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Date of Signature: \_\_\_\_\_