Jillan Cantor Sackett, MD. MS.

Synergy Psychiatry VT

Child, Adolescent, Adult Psychiatrist

Shelburne, VT

**AUTHORIZATION TO EXCHANGE INFORMATION**

I give **Jillan Sackett, MD. MS.** permission to exchange written and/or verbal information regarding my mental health, physical health, psychiatric care, psychological symptoms or issues, substance abuse and any other clinically relevant information on behalf of **myself/my child:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**With**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be exchanged includes, but is not limited to, history, opinions, treatment plans, progress, results, reports, medications for the purpose of educational planning, treatment coordination and/or medical management.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Relationship (if signing for minor**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This release may be revoked at any time with written permission.

Renewal of authorization:

Signature/name/date: