Synergy Psychiatry VT

Jillan Cantor Sackett, MD. MS.

Child, Adolescent, Adult Psychiatrist

Shelburne, Vermont 05482

**Authorization for Release for the use of phone, email, text and voicemail communications**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name, DOB) grant consent for my psychiatrist **Jillan Cantor Sackett, MD. MS.** to correspond with me via phone, email, text and voicemail for the purpose of scheduling appointments, treatment planning, medications, diagnosis or conveying general information about my care. I understand that these modes are not secure forms of communication and that confidentiality cannot be ensured. *Please be advised that email and voicemail are not to be used in order to communicate urgent matters nor emergencies*.

Please **initial here** to indicate you understand and agree to above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand I am entitled to revoke this authorization at any time, but not retroactive to the release of information made in good faith, by writing to the above specified party. I understand that information released by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

It has been explained to me that if I decline to consent to this release of information, the following are the consequences: limited ability to treat and communicate.

**Signature of Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number**: (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) patient has chosen to receive a copy of this form

( ) patient has chosen not to receive a copy of this form