P. O. Box 345
Richmond, VT 05477
Phone: (802) 922-1612

email: cath.burns@synchrosaic.com

CATHERINE E. BURNS, PH.D.
Licensed Psychologist - Doctorate

INFORMED CONSENT FOR RELEASE OF INFORMATION

Client Name: _____Date of Birth: ___/___/___

In order to facilitate psychological evaluation and/or treatment, I authorize Dr. Catherine E. Burns to disclose protected health information, as specified below, to and request protected health information from:

Name: _____

Organization/Primary Care Practice: _____

Address: _____

_____

Phone: _____

Please release the following protected health information:

Date Range:

Description of Records:

□ Release all records for this timeframe

OR

□ Other (please describe):

Restrictions, if any: _____

I also authorize Dr. Burns to use the Electronic Health Record at Essex Pediatrics to maintain all records related to my, or my child's, care. I understand that this means all therapy notes

P. O. Box 345
Richmond, VT 05477
Phone: (802) 922-1612

email: cath.burns@synchrosaic.com

and other records will be contained in the Essex Pediatrics Electronic Health Record where they can be reviewed by Essex Pediatrics medical staff.

I agree to and understand the following:

- I may revoke this consent at any time by notifying the above named clinician in writing, except to the extent that action has already been taken based on my previous consent. This consent will be effective unless and until I revoke it in writing.
- The information released in response to this consent may be disclosed by the recipient and may no longer be protected by federal or state law.
- I am not required to sign this consent. My treatment cannot be conditioned on the signing of this of this consent.

I have read this form and certify that I understand its contents.

This authorization will expire one year from the date of this signature.

Signature of parent/guardian (if client is under 18): _____

Date: _____