Amanda Sun, M.D.
Child, Adolescent and Adult Psychiatry
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INFORMATION AND CONSENT FORM

Patient Name: _____ Date of Birth: _____

Please sign initials on lines below to indicate consent/acknowledgement.

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT

_____ I give consent to Amanda Sun, M.D. to release health information by mail, phone, or fax to staff at my/my child's pharmacy for purposes of prescribing medication or clarifying medication issues. If my/my child's health plan requires pharmacy benefit management (PBM), I give consent to Amanda Sun, M.D. to release information to the PBM for the purpose of prescribing medication or clarifying medication issues.

_____ I give consent to Amanda Sun, M.D. to release health information by mail, phone, or fax to staff at laboratories (Quest, LabCorp, hospital labs, etc.), or by way of their respective online portals, or to electronic medical record providers with lab portals, such as Luminello, for the purpose of providing laboratory services.

_____ I give consent to Amanda Sun, M.D. to release health information by mail, phone, or fax to my/my child's health care providers as described in the *Notice of Privacy Practices*, although specific authorization with verbal and written permission is preferred.

CONSENT FOR RELEASE OF INFORMATION FOR HEALTHCARE OPERATIONS

_____ I give consent to Amanda Sun, M.D., to share necessary health information with staff it may hire to assist with billing, scheduling, or other operations.

CONSENT FOR RELEASE OF INFORMATION FOR APPOINTMENT REMINDERS, TREATMENTALTERNATIVES, OR HEALTH-RELATED PRODUCTS OR SERVICES

_____ I give consent to Amanda Sun, M.D. to contact me by phone or e-mail if she offers appointment reminders, treatment alternatives, or health-related products or services.

CONSENT FOR RELEASE OF INFORMATION TO INSURANCE PLAN AND ASSIGNMENT OF BENEFITS

_____ I give consent to Amanda Sun, M.D. to release medical information to my/my child's insurance company. I certify that the information I have reported with regard to my/my child's insurance coverage is correct. I give consent for the release of any necessary medical information for this or any related claims, in writing (i.e. treatment plans) or verbally (i.e. requesting benefit/authorization information by phone). I permit a copy of this consent to be used in place of the original. I may revoke this consent at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided. If my/my child's insurance company limits visits, I accept responsibility for monitoring the number of allowed sessions used. I agree to pay for all non-covered services, including late cancellations/missed appointments, telephone appointments, services provided after benefit exhaustion, and services determined not to be necessary by my/my child's insurance carrier.

POLICY FOR RELEASE OF INFORMATION IN SPECIAL SITUATIONS

_____ I understand that Amanda Sun, M.D. may disclose health information about me/my child in the event of a serious threat to the health and safety of myself or others, in the event of suspected child or elderly abuse or neglect, or in situations detailed in the *Notice of Privacy Practices*.

NOTICE OF PRIVACY PRACTICES

_____ I have received a copy of Dr. Sun's *Notice of Privacy Practices*.

Signature: _____ Date: _____