Amanda Sun, M.D.
Child, Adolescent and Adult Psychiatry
1122 Kenilworth Drive, Suite 100
Towson, MD 21204
Phone/Fax: 410-881-4639

AUTHORIZATION FOR RELEASE OF INFORMATION TO/FROM THIRD PARTIES

Patient Name: _____ Date of Birth: _____

I authorize Amanda Sun, M.D. for the purpose of psychiatric evaluation, diagnosis, treatment and coordination of care to:

_____ RELEASE _____ RECEIVE (check either or both) my health information to/from the following (i.e. your primary care physician, therapist, family member, etc.):

1) Name: _____
Address: _____
Phone/Fax/Email: _____

2) Name: _____
Address: _____
Phone/Fax/Email: _____

3) Name: _____
Address: _____
Phone/Fax/Email: _____

If Amanda Sun, M.D. is to be the recipient, my health information should be sent to:

Amanda Sun, M.D.
Address - 1122 Kenilworth Drive, Suite 100 Towson, MD 21204
Phone/Fax - 410-881-4639
Email - suna@amandasunmd.com

"My health information" means (check at least one option):

___ **Complete Record**
___ Discharge Summary
___ Outpatient Health Records
___ Mental Health Records
___ Psychosocial Assessment
___ Progress Notes
___ History of Allergies
___ Emergency Room Record
___ Diagnostic Test Results
___ Verbal Communications
___ Drug/Alcohol Treatment Record
___ Psychological/Educational Report
___ Classroom Observations
___ Psychiatric Evaluation/Diagnosis
___ Psychiatric Admission/Hospital Notes
___ Other _____

I understand that once my health information is disclosed as requested in this authorization my health information may no longer be protected by federal and state privacy laws and potentially may be redisclosed by the person receiving the information.

I understand that I am not required to sign this authorization. Amanda Sun, M.D. does not condition treatment on the signing of this form. I may revoke this authorization by mailing/faxing my request to Amanda Sun, M.D.

Patient Name: _____
Patient Signature (if over 18 years): _____ Date: _____
Parent/Guardian/Authorized Representative Name: _____
Parent Signature: _____ Date: _____