PEDIATRIC HELPING HANDS THERAPY

2 Chelsea Boulevard
Houston, Texas 77006
Phone: 713-807-1131
Fax: 713-807-1141

Authorized Release of Protected Health Information (PHI)

Please list all professionals who have regular contact with your child (i.e. Pediatricians, Developmental Specialists, Therapists, Teachers, Nannies, Caregivers, etc.)

Name of Person/Entity	Phone #	Place of Employment	Date of Release	Authorization to Release PHI

_____ _____

Signature of Parent/Legal Guardian Date

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Authorizations & Releases

Patient Name: _____ Patient DOB: _____

All authorizations and releases of information on this form are valid for the duration of treatment unless the client cancels the authorization by written notice.

CONSENT FOR TREATMENT

I, the undersigned, voluntarily consent to the rendering of care, including treatment, evaluation, and home program. I understand that I am under the care and supervision of the performing provider.

_____ _____
Printed name of Parent/ Guardian Date

_____ _____
Signature of Parent/Guardian Date

AUTHORIZATION / ASSIGNMENT TO PAY BENEFITS

I, the undersigned, hereby authorize payment to my child's therapist(s) and/or Pediatric Helping Hands Therapy of the medical benefit, if any, otherwise payable to me for the services. I understand that I am financially responsible for my child's treatment charges and supplies including co-pay, deductibles, and co-insurance amounts not covered by this assignment of benefits.

_____ _____
Signature of Parent/Guardian Date

AUTHORIZATION TO DISCUSS CLINICAL CARE

I, the undersigned, hereby authorize my child's therapist(s), their employee, and/or their contractor to discuss clinical care with other therapists and professionals associated with Pediatric Helping Hands Therapy. I also realize that students from various local universities may attend Pediatric Helping Hands Therapy to observe treatment strategies with my child or to perform a supervised internship that may involve my child.

_____ _____
Signature of Parent/Guardian Date

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RELEASE OF INFORMATION

I, the undersigned, hereby grant consent to Pediatric Helping Hands Therapy to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations.

Our Notice of Privacy Practices for Protected Health Information provides more detailed information about how we may use and disclose this protected health information. You have the legal right to review our Notice of Privacy Practices for Protected Health Information before you sign this release, and we encourage you to read it in full.

Our Notice of Privacy Practices for Protected Health Information is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (713)-807-1131. You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or healthcare operations. We are not required by law to grant your request; however, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this release in writing, except to the extent that we may have already used or disclosed your protected health information in reliance on your consent.

_____ _____

Printed name of Parent/ Guardian Date

_____ _____

Signature of Parent/Guardian Date

AUTHORIZATION FOR VIDEO/PICTORIAL CLINICAL RECORDS

I, the undersigned, authorize my child's therapist, and/or their employee, and/or their contractor to videotape or take photographs of my child for clinical evaluation and record keeping purposes.

_____ _____

Printed name of Parent/ Guardian Date

_____ _____

Signature of Parent/Guardian Date

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Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a Notice of Privacy Practices for Protected Health Information (PHI) which provides a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:

___The right to review the notice prior to signing this consent.

___The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

_____	_____
Printed name of Patient	Date
_____	_____
Printed name of Parent/ Guardian	Date
_____	_____
Signature of Parent/Guardian	Date

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Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy for Pediatric Helping Hands Therapy, LLC, JMST for Kids, Inc., MVPT for Kids, Inc., and/or Speech Tree, Inc. A copy of the signed and dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment records to be sent to other attending physicians or therapists in the future.

_____ _____
Printed name of Patient Patient Date of Birth

_____ _____
Signature of Patient or Parent/Guardian Date

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS YOUR CHILD'S MEDICAL TREATMENT INFORMATION AND/OR BILLING RECORDS. (This includes step parents, grandparents, educators, and any caretakers who may require access to this patient's records.)

Name: _____Relationship:_____ ___Medical ___Billing

Name: _____Relationship:_____ ___Medical ___Billing

Name: _____Relationship:_____ ___Medical ___Billing

Name: _____Relationship:_____ ___Medical ___Billing

I authorize contact from this office to CONFIRM MY CHILD'S APPOINTMENTS, TREATMENT, AND BILLING INFORMATION VIA:

___Cell phone: _____
___Home phone: _____
___Work phone: _____
___Email Address: _____
___ All/Any of the above

I authorize contact from this office to convey INFORMATION ABOUT MY CHILD'S MEDICAL HEALTH VIA:

___Cell phone: _____
___Home phone: _____
___Work phone: _____
___Email Address: _____
___All/Any of the above