MVPT FOR KIDS, PLLC
PEDIATRIC THERAPY

2 Chelsea Boulevard Houston,
TX 77006
Phone: (281)703-6530
Fax / Phone: (281)619-5499

AUTHORIZATION(s) & RELEASE(s)

Patient Name: _____ **Date of Birth:** _____

ALL AUTHORIZATION(s) AND RELEASE(s) OF INFORMATION ON THIS FORM ARE VALID FOR THE DURATION OF TREATMENT UNLESS THE CLIENT CANCELS THE AUTHORIZATION BY A 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.

_____ _____
Signature of Parent or Guardian Date

AUTHORIZATION / ASSIGNMENT TO PAY BENEFITS:
I, the undersigned, hereby authorize payment to my child's therapist and/or MVPT For Kids, PLLC. 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 and amounts not covered by this assignment of benefits.

_____ _____
Signature of Parent or Guardian Date

AUTHORIZATION TO DISCUSS CLINICAL CARE:
I, the undersigned, hereby authorize my child's therapist, and/or their employee and/or their contractor to discuss clinical care with other therapists and professionals associated with the MVPT For Kids, PLLC. I also realize that students from various local Universities will be attending the MVPT For Kids, PLLC. to observe treatment strategies with my child or to perform a supervised internship that may involve my child.

_____ _____
Signature of Parent or Guardian Date

RELEASE OF INFORMATION:

I. the undersigned, hereby grant consent to **HELPING HANDS PEDIATRIC THERAPY** to use and disclose my protected health information for the purposes of treatment, payment and health care 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 a 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 a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care 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

_____ _____

Signature of Parent or 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.

_____ _____

Signature of Parent or Guardian Date