EDUCATING
PROTECTING
HEALING

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AUTHORIZATION FOR CONSENT TO RELEASE PHI (PROTECTED HEALTH INFORMATION)

BY SIGNING THIS FORM, I AM HEREBY AUTHORIZING THE RELEASE OF CONFIDENTIAL HEALTH INFORMATION ABOUT MYSELF or MY CHILD. THE MEDICAL RECORDS, INCLUDING ANY AND ALL OF THE FOLLOWING REPORTS LISTED BELOW, ARE PHI THAT MAY BE RELEASED TO AND FOR USE BY THE PERSONS/FACILITY/ENTITY LISTED BELOW.

CLIENT: _______________________________________ DATE OF BIRTH: ____________________

PARENT/CAREGIVER SIGNATURE: ____

INFORMATION THAT MAY BE RELEASED:

DIAGNOSTIC REPORT	BACKGROUND/HISTORY	CLINICAL LAB REPORT
PLAN OF CARE	PHYSICAL	PROGRESS REPORTS
PATHOLOGY REPORTS	TREATMENT NOTES	HOSPITALIZATIONS
VACCINATION HISTORY	MEDICATION RECORDS	OPERATION REPORT
VACCINATION RISK ASSESSMENT	EPIGENETIC TESTING RESULTS	SCHOOL RECORDS

RELEASE OF THIS PERSONAL HEALTH INFORMATION IS ENDORSED FOR THE FOLLOWING PRACTITIONER/COMPANY & ANY PERSON ASSOCIATED WITH THIS ENTITY REQUIRING DIRECT ACCESS TO PRIVATE HEALTH REPORTS:

NAME: Mighty Oaks Therapies
ADDRESS: 17774 Cypress Rose Hill, Suite 320
CITY/ST/ZIP: Cypress, Texas 77429

MINOR'S MEDICAL CONSENT:

- I HEREBY CONSENT TO THE TREATMENT OF MY MINOR CHILD BY THE ABOVE-NAMED ENTITY/PRACTITIONER. ________ (initials)
- AS PARENT, I GIVE PERMISSION, FOR MY CHILD'S CAREGIVER ____________________________ TO PARTICIPATE IN SESSIONS AS DEEMED NECESSARY BY THE PRACTITIONER. THIS MAY INCLUDE DISCUSSION OF CLIENT's PROGRESS OR THERAPEUTIC ACTIVITIES AS WELL AS PROVIDING TRANSPORTATION TO/FROM THERAPY SERVICES.

SIGNED:____