Teen Health Center, Inc.
Providing free medical and mental health care to Galveston County youth since 1985

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name:____ Date of Birth:__________________
Other Names You have Used: _____________________________ Phone:__________________________

If this Authorization is for any purpose other than the release of PHI for personal reasons, please mark the purpose: _________Continuity of Care _________Treatment Purposes ___________________ Other (_________________________)
I am requesting records from (date)___________________ through (date) _________________________

I specifically authorize the use and disclosure of the following PHI: (Please provide a detailed description of the particular data and period of time you are requesting)

O Progress Notes
O Psychological Test Results
O Other ____________________________
O Emergency Records
O Lab Reports
O Shot Records
O Verbal Communications/Phone Call

I authorize the release of medical records indicated above FROM:

Name: Teen Health Center, Inc.
Address: PO Box 925, Galveston, Texas 77553
Telephone Number: 409-766-5750 Fax Number: 409-765-5026

I authorize the release of medical records indicated above TO:

Name:____
Address:____
Telephone Number: _______________________________ Fax Number:_____________________

By signing this Authorization Form, I understand that I am giving my authorization for the Teen Health Center, Inc. to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy process notes maintained separately by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying the Teen Health Center, Inc. in writing to: Teen Health Center, Inc. PO Box 925, Galveston, Texas 77553-0925 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by the Teen Health Center, Inc. before the Teen Health Center, Inc. received my written notice of revocation. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from Teen Health Center, Inc.

Signature of Patient:____

Authorized Personal Representative:____

Authorized Person's Relationship to the Patient:____

Date:____

This authorization will expire on the 180th day from its signing unless a lesser date is specified here____________