



Teen Health  
Center, Inc.

**Patient Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

No. & Street name

City

State

Zip Code

**Authorization:**

By signing this form, I authorize release of the protected health information indicated below, including, if applicable, any treatment or test results for mental health, alcohol, and/or drug abuse, or reportable communicable diseases, including acquired immune deficiency syndrome or human immuno-deficiency virus infection to:

Provider, Facility Name, or Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Entire Health Record

Medical Records Only

Mental Health Records Only (counseling and/or psychiatry)

Partial Records: From: (start) \_\_\_\_\_ to: (end) \_\_\_\_\_

Other (please specify): \_\_\_\_\_

**Method of Transmission:**

Fax Number: \_\_\_\_\_

Pick up: Address Teen Health Center, Inc. (Ball High School Clinic) 4115 Avenue O, Galveston, TX 77550

Email: *(Emails are encrypted, but you assume responsibility for any unexpected breach of confidentiality that may occur via electronic transmission.)* \_\_\_\_\_

**Reason for request:**

Moving out of area

New medical provider or mental health provider

Other (please specify): \_\_\_\_\_

**Fees:**

Records other than those sent to another qualified healthcare provider are subject to a fee of .10c per page.

Patient signature OR signature of legal representative: \_\_\_\_\_ Date: \_\_\_\_\_

If applicable, printed name of legal representative: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Please return completed form with a copy of your government-issued photo ID, such as a driver license, to Teen Health by mail, fax, or in person. If mailed or faxed, this form must be signed by a notary.

**Note:** State law gives Teen Health the right to deny records requests if our providers believe that release of records would be harmful to the patient's physical, mental, or emotional health. Also, minors have legal, exclusive rights to certain records (i.e. treatment/test results for reportable communicable diseases).