



Dear Patients, Families, Friends, and Colleagues,

It is with very mixed emotions that we write to inform you that Our Place Adolescent and Young Adult Health will be closing our doors on June 30, 2026. While this has been a very difficult, and to be honest, painful decision, we also want to very quickly reassure you that this does not mean that you are getting rid of us.

Our affiliates (our counselors and dietitians) will continue their work as always, though from different spaces. We will of course be providing any new contact and location information for each of our team members as it is available.

Yours truly, Dr. Parcels, is excited to announce that I am planning on joining the faculty at the UNT Health Science Center. I will be starting as the Pediatric Clerkship Director October 1 of this year and seeing patients in clinic starting in January.

Dr. Stone is still determining where the next chapter will take her, but she is planning to continue seeing patients.

Why are we closing?

Without going into all the details, it is largely due to the current state of our medical system combined with personal, familial, and professional reasons. Suffice it to say though, that we are hoping these changes, though difficult, will give us the opportunity to continue serving our patients while also enabling us to expand our impact by teaching future and current physicians and other providers as well as working to advocate for change in that very same medical system.

What is next?

If you are wanting to continue care with Drs. Parcels or Stone after June 30, Dr. Priya Bui (Chair of Pediatrics) and our colleagues at the UNTHSC Pediatric Clinic have offered their services to our patients to bridge the gap. You can call to make an appointment with them at 817-735-2363, and when you do please specify that you are a patient of Dr. Parcels or Dr. Stone. If you would like to transition care to another provider, we are happy to assist with that process. Please keep an eye on your email. In the coming weeks and months, as we determine all the logistics, we will be sending you updates as soon as they are available in order to aid in the transition.

Lastly, but certainly not least, I want to thank every single one of you from the bottom of my heart. This is truly OUR PLACE. Not mine. OURS. Every one of our patients, family members, staff, affiliates, team members, friends, made this clinic...this community what it is. And it is just that – a community. It has been truly a privilege and gift to be a part of each of your journeys. This is not goodbye, it is see you soon.

With genuinely all the love in my heart,
Carolyn Lentzsch Parcels, MD



Dear Patients and Families,

The purpose of this notice is to again let you know that Our Place Adolescent and Young Adult Health will permanently close and will no longer be available to provide for your healthcare needs effective June 30, 2026. I recommend that you arrange alternative care with another healthcare provider or practice as soon as possible. If you are not acquainted with other providers in the area, you may search your health plan's provider directory, contact us for a list of providers, or you may also contact UNTHSC Pediatric Clinic at 817-735-2363 to schedule an appointment (please tell them you are a Dr. Parcels or Dr. Stone patient – see our previous communication for more details.)

If you have already identified an alternative provider or practice, please contact our office no later than June 15, 2026, to obtain copies of your medical record or to request that copies of your records be transferred to your new provider or practice. Your medical records are confidential, and as you all know we take your confidentiality very seriously. Therefore, to request a transfer of your records to another provider OR to receive a copy of your records, you MUST complete, sign and return to our office, the enclosed medical records release authorization. This form can also be found on our website or can be requested by calling our office at 817-524-1811.

At this time, we are still evaluating options and procedures for you to request your records or to have your records sent to other providers once our office is closed, but we will provide that information as soon as it is available. That information will also be available on our website www.ourplacehealth.org.

If you have any questions, please contact us at (817-524-1811).

All my Best,

A handwritten signature in black ink, appearing to read "Carolyn", with a long horizontal flourish extending to the right.

Carolyn Lentzsch Parcels, MD

Click Download Button for: Patient Authorization Form for Release of Medical Records



4200 South Hulen St., Ste 450 Fort Worth, Texas 76109
Phone 817-524-1811 Fax 833-973-6190

Patient Name: _____ Date of Birth: ____/____/____

Please provide me with a copy of the above patient's medical records.

Information to be disclosed. If all health information is to be released, then check ONLY the FIRST box.

- ALL Health Information:** including Medical Summary, Immunization/Growth Charts, Lab/Radiology Reports
 - Immunization Records/Growth Charts
 - Lab/Radiology/Testing Records
 - Mental Health Records (excluding psychotherapy notes)
 - Other (please specify) _____

Patient's Initials are required to release the following information:

- _____ Mental Health Records (excluding psychotherapy notes)
- _____ Genetic Information (Including Genetic Testing Results)
- _____ Drug, Alcohol or Substance Abuse Records
- _____ HIV/AIDS Test Results/Treatment

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation will be effective upon receipt by OUR PLACE ADOLESCENT & YOUNG ADULT HEALTH (formerly Girls to Women, Young Men's Health & Wellness). I have read and understand the terms of this Authorization, and hereby knowingly and voluntarily authorize OUR PLACE ADOLESCENT & YOUNG ADULT HEALTH to disclose my health information in the manner described above. This authorization expires upon my written request.

I UNDERSTAND THAT THERE WILL BE A CHARGE OF \$25 FOR THE FIRST 20 PAGES AND .50 FOR EACH PAGE THEREAFTER FOR MEDICAL RECORDS PROVIDED.

_____ I WILL PICK UP THE MEDICAL RECORDS AT THE CLINIC.

_____ PLEASE EMAIL THE RECORDS TO: _____

I UNDERSTAND THAT I WILL NEED TO PAY FOR THE RECORDS AND THE MAILING COST IF MAILED PRIOR TO RECEIPT OF THE RECORDS.

Patient's Signature (18 years or age or older): X _____ Date: ____/____/____
Patient signature (adult patient's only)

Minor's Signature: a minor's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

X _____ Date: ____/____/____
Minor Signature (minor patients only)

Parent/Guardian's Signature: Specify relationship to patient Parent of Minor Guardian Other: _____
X _____ X _____ Date: ____/____/____
Parent/Guardian (print) if patient is a minor Parent/Guardian (signature) if patient is a minor



4200 South Hulen Ste. 450 Fort Worth, Texas 76109
Phone 817-524-1811 Fax 833-973-6190

PATIENT NAME: _____ DATE OF BIRTH: _____



ALLOW COMMUNICATION to and from the PROVIDER (IN BOX BELOW) and OUR PLACE ADOLESCENT & YOUNG ADULT HEALTH/formerly Girl's Top Women Young Men's Health & Wellness/AYA, our in-house licensed therapists / dietitians as needed including all medical and mental health protected health information (excluding psychotherapy notes). I authorize the following providers to disclose the patient's protected health information for treatment / continuing medical

PROVIDER information:
Name: _____ Phone: _____
Practice / Group Name: _____
Address: _____ Fax: _____

- Request protected health information FROM the PROVIDER listed in provider box above
Complete Records
Immunization Records
Growth Charts
Labs / Radiology / Testing Reports
Mental Health Records (excluding psychotherapy notes)
Other (please specify)

SEND protected health information TO THE PROVIDER listed in the PROVIDER BOX above
Complete Records
Immunization Records
Growth Charts
Lab/ Radiology/ Testing Reports
Mental Health Records (excluding psychotherapy notes)
Other (please specify)

REQUIRED PATIENT INITIALS for Release of ANY OUR PLACE ADOLESCENT and YOUNG ADULT HEALTH Records

- Mental Health Records (excluding psychotherapy notes)
Genetic Information (including Genetic Testing Results)
Drug, Alcohol or Substance Abuse Records
HIV / AIDS Test Results / Treatment

A minor individual's signature is required for the release of certain types of information, including for example; the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation will be effective upon receipt by OUR PLACE ADOLESCENT and ADULT HEALTH. I have read and understand the terms of this Authorization, and hereby knowingly and voluntarily authorize OUR PLACE ADOLESCENT and ADULT HEALTH to use and disclose my health information in the manner described above. This authorization expires upon my written request.

REQUIRED PATIENT SIGNATURE X _____ (Patient Signature) _____ / _____ / _____ (Date)

Parent / Guardian's Signature (Only required for patients less than 18 years of age):
Specify relationship to parent: ___ Parent of Minor ___ Guardian ___ Other _____

X _____ (Parent Signature) X _____ (Parent / Guardian Signature if patient is a minor)