

**Trent C. Holmberg, M.D.**

12481 S. Fort Street, Suite 275

Draper, Utah 84020

Phone: 801-432-2077 Fax: 801-432-2079 Email: tchmdpc@gmail.com

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

(For Patients Requesting A Copy Of Their Own Medical Records)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

**This authorization is to release protected health information from:**

Trent C. Holmberg, M.D.  
12481 S. Fort Street, Suite 275  
Draper, Utah 84020

**Reason for Obtaining Records:** \_\_\_\_\_

**Dates of service requested:** \_\_\_\_\_

**Release the following information:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> All Information               | <input type="checkbox"/> Treatment Plans     | <input type="checkbox"/> Itemized Billing Statements |
| <input type="checkbox"/> Consultations/Evaluations     | <input type="checkbox"/> Psychiatric Testing | <input type="checkbox"/> Rating Scales               |
| <input type="checkbox"/> Progress Notes                | <input type="checkbox"/> Lab Reports         | <input type="checkbox"/> Medications/History         |
| <input type="checkbox"/> Drug/Alcohol Treatment        | <input type="checkbox"/> Emergency Records   | <input type="checkbox"/> Appointments/Scheduling     |
| <input type="checkbox"/> Other - Please Specify: _____ |  |  |

**I understand that:**

- Once I have obtained a copy of my own medical records as a result of this authorization, they are no longer protected by HIPAA privacy rules and it will be my responsibility to protect the privacy of my records once they are in my possession.
- There are privacy risks involved when medical records are mailed, faxed or emailed as they can be intercepted or misdirected. I do not hold Dr. Holmberg or his staff responsible for the privacy of my records once they have been mailed, faxed or emailed at my request.
- Picking up my records in person is the best way to insure their privacy. I may be asked for my I.D. before I am given my records and a copy of that I.D. may be made. If I am sending someone other than myself to pick up my records, I must contact the office first and let them know who will be picking up my records. The office staff will require a valid I.D. and a signed note by the patient before records can be released to anyone other than myself.
- I may at any time request in writing to this office (at the address above), to inspect or obtain a copy of my protected health record maintained at this practice.
- Dr. Holmberg reserves the right to withhold medical information if he reasonably determines that the information would be detrimental to my physical or mental health or would likely cause me to harm myself or someone else.
- I will get the first ten pages of my medical records free of charge. Additional pages will result in a copy fee or the time it takes to fax or scan and email the records. In addition, postage and sales tax may be charged if mailed. You may be invoiced or required to pay applicable fees prior to obtaining the copies. Payment is otherwise due upon receipt of your copies. To get an estimate of charges, please contact the office staff at 801-432-2077.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notary Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_