

**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  
FROM THE OFFICE OF TRENT C. HOLMBERG, MD**

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

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

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

Name of Individual, Company or Provider: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Provider Name: Trent C. Holmberg, M.D.

Address: 12481 S. Fort Street, Suite 275, Draper, Utah 84020 Phone: 801-432-2077

**The reason for this disclosure is:** \_\_\_\_\_

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

**Release the following information:**

- |                                                    |                                                      |                                                                                    |
|----------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------|
| <input type="checkbox"/> Treatment Plans           | <input type="checkbox"/> Itemized Billing Statements | <input type="checkbox"/> Rating Scales                                             |
| <input type="checkbox"/> Consultations/Evaluations | <input type="checkbox"/> Psychiatric Testing         | <input type="checkbox"/> Medications/History                                       |
| <input type="checkbox"/> Progress Notes            | <input type="checkbox"/> Lab Reports                 | <input type="checkbox"/> Appointments/Scheduling                                   |
| <input type="checkbox"/> Emergency Records         | <input type="checkbox"/> Drug/Alcohol Treatment      | <input type="checkbox"/> All Information (Still must check Drug/Alcohol Treatment) |

Other - Please Specify: \_\_\_\_\_

**This authorization will remain in effect until:** \_\_\_\_\_  otherwise notified

**I understand that:**

- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- 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.
- This authorization will remain in effect until I provide written notice of revocation to this office.
- I may refuse to sign or revoke this authorization at any time for any reason and doing so will not affect the quality or continuation of my treatment at this practice.
- If I revoke this authorization, this practice will not be able to reverse any disclosure of my protected health information while this authorization was in effect.
- 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 be responsible for the payment of any costs associated with the copying, mailing or time it takes to fax or scan and email my records to another provider or individual.

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