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

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:

☐ All Information	☐ Treatment Plans	☐ Itemized Billing Statements
☐ Consultations/Evaluations	☐ Psychiatric Testing	☐ Rating Scales
☐ Progress Notes	☐ Lab Reports	☐ Medications/History
☐ Drug/Alcohol Treatment	☐ Emergency Records	☐ Appointments/Scheduling

☐ 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:** _____