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:

☐ Appointments/Scheduling	☐ Treatment Plans	☐ Itemized Billing Statements
☐ Consultations/Evaluations	☐ Psychiatric Testing	☐ Rating Scales
☐ Progress Notes	☐ Lab Reports	☐ Medications/History
☐ Drug/Alcohol Treatment	☐ Emergency Records	☐ ALL Information (must also check drug/alcohol tx)

☐ 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 will be charged if mailed. You may be 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:** _____

Important! Must be signed in presence of a notary to verify identity or not valid.

NOTARY ACKNOWLEDGEMENT

State of Utah }

County of salt lake }

On this ____ day of _____, in the year _____, I, _____ notary public, do herby certify that _____(name of individual whose acknowledgment is being taken), has personally appeared before me and has shown legal proof to be the person who is described in and who executed the within and foregoing instrument and acknowledged that he/she signed the same as his/her voluntary act and deed for the uses and purposes therein mentioned, which is to obtain a record of their own protected health information.

Witness my hand and official seal.

_____
Notary Public Signature

_____
Print Name

My Commission Expires: _____
(Seal)