**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 Full Name:_____ Date of Birth:_____

Current Address:_____ Phone:_____

**This authorization is to release protected health information regarding the above named individual to the office of:**

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

**Name of Provider/Institution/Individual/Company that information or records are being requested from:**

_____

Address: _____Phone: _____ Fax:_____

**The reason for this disclosure is:** _____

**Dates of service requested:** _____

**Release the following information:**

☐ Treatment Plans
☐ Consultations/Evaluations
☐ Progress Notes
☐ Medical Records
☐ Medications/History
☐ Psychiatric Testing/Rating Scales
☐ Lab Reports
☐ Police Reports
☐ Emergency Records
☐ Drug/Alcohol Treatment
☐ All Information (must check Drug/Alcohol Treatment as well)
☐ Other - Please Specify: _____

**This authorization will remain in effect until:** _____ or ☐ 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.
- If I revoke this authorization, I will not be able to reverse any disclosure of my protected health information while this authorization was in effect.

**Patient Signature:** _____ **Date:** _____

**Witness Signature:** _____ **Date:** _____