Scott C. Wyman M.D.
2835 Fort Missoula Rd. Bldg. 3, Ste. #305, Missoula, MT 59804 Phone:(406) 926-1088 Fax:(406) 926-1087

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations:

Patients Name:	Birth Date:	Social Security Number:
Phone Number:		

Provider's Name: SCOTT C. WYMAN MD	Recipients Name: 164.508(c)(1)(iii)		
Provider's Address: 2835 FORT MISSOULA RD STE #305 MISSOULA, MT 59804	Address 1:		
	Address 2:		
	City:	State:	Zip:

Expiration Date or Event: This authorization will expire on the following expiration date (or) expiration event: 164.508(c)(1)(v)

Date:	Event:

Purpose of Disclosure: 164.508(c)(1)(iv)

Description of Information to be Used or Disclosed

Is this request for psychotherapy notes?

- ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. 164.508(b)(3)(ii)
- ☐ No, then you may check as many items below as you need. 164.508 (c)(1)(i)

Description:	Date of Service	Description:	Date of Service
☐ All PHI in Medical Records		☐ Mammograms	
☐ Progress Notes		☐ Operative Information	
☐ Labs		☐ Labor & Delivery Summary	
☐ Pathology		☐ Other	
☐ X-ray		☐ Other	

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid. 164.508(c)(1)(vi)
2. I understand that protected health information may include information and records protected under Federal and State Law such as: general public health activities, other public health activities i.e.: child abuse or neglect, product or activity regulated by the FDA, persons at risk of contracting or spreading a disease, workplace medical surveillance. 164.512(b)(1(i), 164.512(b)(ii), 164.514(d)(3(iii),
3. I understand that protected health information may include information and records protected under Federal and State Law such as: alcohol, drug abuse, mental health, AIDS, or HIV testing or treatment.
4. My treatment, payment, enrollment or eligibility for benefits may not be conditioned or signing this authorization. 164.508 (c)(2)(ii)
5. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 164.508 (c)(2)(i)
6. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 164.508 (c)(2)(iii)
7. There may be a reasonable fee to obtain a copy of the information be requested on this form. 164.524(c)(4)
8. I get a copy of this form after I sign it. 164.508(c)(4)

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Section B: Is the request of PHI for the purpose of marketing? 164.508(a)(3)(ii)	
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.	
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No If yes, describe:	
Section C: Required Signatures 164.508 (c)(1)(vi)	
I have read the above and authorized the disclosure of the protected health information as stated.	
Signature of Patient/Guardian/or Personal Representative:	Date Signed:
Printed Name of Patient/Guardian? Or Personal Representative:	Relationship to Personal Representative or Patient: