HOMETOWN FAMILY MEDICINE
AND WOMEN'S HEALTH

Scott C. Wyman, MD
Diana M. Podlecki, PA-C
2835 Fort Missoula Road Suite 305
Missoula, MT 59804
Phone: 406-926-1088
Fax: 406-926-1087

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

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

Provider's Name:	Recipient(s) Name: Scott Wyman, MD & Diana Podlecki, PA-C		
	Address 1: 2835 Fort Missoula Rd, Suite 305		
Provider's Fax Number:	Fax Number: 406-926-1087		
	City: Missoula	State: Montana	Zip: 59804

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

Date: Event:

Purpose of Disclosure:

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.

☐ No, then you may check as many items below as you need.

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.
2. I understand that protected health information may include information and records protected under Federal and State Law such as: 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 disease, workplace medical surveillance.
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 of eligibility for benefits may not be conditioned or signing this authorization.
5. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
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 disclosed.
7. There may be a reasonable fee to obtain a copy of the information be requested on this form.
8. I get a copy of this form after I sign it.

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Section B: Is the request of PHI for the purpose of marketing?	
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	
Signature of Patient/Guardian/or Personal Representative:	Date Signed:
Printed Name of Patient/Guardian/or Personal Representative:	Relation to Personal Representative or Patient: