NORTH IDAHO UROLOGY

980 Ironwood Drive, Suite 104
Coeur D' Alene, ID 83814
PH: (208) 667-0621 Fax: (208) 664-1709
Dr. Charles Gates
Dr. Randil Clark
Dr. Edward Ellison
Dr. Matt McLaughlin
Dr. Chad Peterson
Marti Stow, ARNP

RELEASE OF MEDICAL RECORDS REQUEST

Patient Name:____

Date of Birth:____

I hereby request that you release

To/From: ___________________________	To/From: ___________________________
Address:____________________________	Address:____________________________
____________________________	____________________________
Phone: ____________________________	Phone: ____________________________
Fax: ____________________________	Fax: ____________________________

Any reports of my diagnosis, treatment (current and past), prognosis and recommendations, as well as other data pertinent to my treatment and medical history. (labs, radiology & pathology reports, surgical history, etc.)

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Patient signature   Date