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## MEDICAL RECORDS RELEASE FOR PROTECTED HEALTH INFORMATION

From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I request a copy or summary of the following medical records:

- Complete Medical Record
- Biopsy Report(s)
- Lab Report(s)
- Surgical Procedure(s)
- Other \_\_\_\_\_

Please check one:

- For dates of service from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_
- For all dates of service

Additional Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Date