Bowie Internal Medicine Associates
14999 Health Center Drive, Suite 201
Bowie, Maryland 20716
Phone: (301)262-8188
Fax: (301)464-8233
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Records Release Authorization

Patient's Name: _____

Address: _____
_____

Date of Birth: _____

I hereby authorize Bowie Internal Medicine Associates, Dr. Siegel, Dr. Wang, Dr. Thomas, Dr. Sachdev, Janet Beebe, CRNP, and Jo Greenberg, CRNP to release a copy of my medical records, x-rays, and/or lab test results to:

Name:_____

Address: _____

At the address listed above concerning my illness during the time period listed below:

From: _____ To: _____

Signature: _____ Date: _____

Witness: _____

Things you should be aware of:
No limitations are place on dates, history, or illness, or diagnostic and therapeutic information, including any treatment pertaining to psychiatric, sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), human immunodeficiency virus (HIV), drug and/or alcohol related illness unless specified.

There will be a fee for preparation and copying of records due at the time the records are prepared.