Bowie Internal Medicine Associates
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Record Release Request

To: _____
(Doctor or Hospital)

Fax/Address:_____

I hereby request you release, for use in my medical treatment, a copy of my medical records, x-ray and/or lab tests results to:

___David L. Siegel M.D. ___Lizy Thomas, M.D. ___James Y. Wang, M.D.
___Ritu M. Sachdev, M.D. ___Janet M. Beebe, CRNP ___Jo Greenberg, CRNP

at the address listed above concerning my illness/es during the period of time listed below.

Things you should be aware of:
The office that you are requesting records from holds the right to charge you for the copying and distribution of your medical records, YOU MAY BE BILLED. No limitations are placed on dates, history or illness, or diagnostic and therapeutic information, including any treatment pertaining to psychiatric, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), drug and/or alcohol related illness unless specified:

From: _____To:_____

Name: _____Date of Birth:_____

Address:_____

Signature:_____Date:_____

This request is valid for 90 days from date above. The patient may revoke this request, in writing prior to the expiration date.

If you are unable to locate these records or have no records of seeing the above named patient, please check off the appropriate box below and return to our office. Thank you.

- o Unable to locate records
- o No record of above patient
- o Records are too old and no longer available