

Teresa Hoffman, M.D. & Associates, LLC
Obstetrics & Gynecology

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Records Release Form

Date: ____ - ____ - ____

Patient Name: _____

Date of Birth: ____ - ____ - ____

Social Security #: ____ - ____ - ____

I hereby request that my medical records from _____
_____ at _____
_____ be sent to following physician group:

Teresa Hoffman M.D. & Associates, LLC
6610 Tributary Street, Suite 206
Baltimore, MD 21224

Previous Name: _____

Dates: _____ to _____ or ALL

Thank You,

Signature of Patient