

# Release of Medical Records



## REQUEST FOR RELEASE OF MEDICAL RECORDS

In accordance with Maryland state law, a \$10.00 check or money order made payable to Teresa Hoffman, M.D., must accompany this authorization. Please mail this completed form and the required payment to:

**Teresa Hoffman, M.D., & Associates, LLC**  
**3601 O'Donnell Street**  
**Suite 150**  
**Baltimore, Maryland 21224**

Records will be released within five business days upon receipt of authorization and payment.

I hereby request that my medical records be released to:

Physician's Name (Print) \_\_\_\_\_

Address \_\_\_\_\_

City, State Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Patient's Name (Print) \_\_\_\_\_

Patient's Signature Date \_\_\_\_\_

Address \_\_\_\_\_

City, State Zip Code \_\_\_\_\_

Birth Date \_\_\_\_\_

Social Security Number \_\_\_\_\_

BALTIMORE  
341 N. Calvert Street  
Suite 201  
Baltimore, Maryland 21202

BALTIMORE WEST  
7001 Johnnycake Road  
Suite 105  
Windor Mill, Maryland 21244

BALTIMORE EAST  
3601 O'Donnell Street  
Suite 150  
Baltimore, Maryland 21224

CONTACT  
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fax: 410-633-6736  
web: hoffmanobgyn.com