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

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

CATONSVILLE
7001 Johnnycake Road
Suite 105
Windsor Mill, Maryland 21244

DUNDALK
6610 Tributary Street
Suite 206
Baltimore, Maryland 21224

CONTACT
office: 410-633-6300
fax: 410-633-6736
web: hoffmanobgyn.com