Records Release Form

Hoffman and Associates OB/GYN

Date: _____ /_____/_____

Patient Name: _____

Date of Birth: _____ /_____/_____

Social Security #: _____-_____-_____

I hereby request that my medical records from

_____ Phone: _____

be sent to following physician group:

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

Requesting:

☐ Pap Smear/Cultures ☐ Operative Reports ☐ Prenatal records/Labs ☐ Other: _____
(Please specify)

Dates: _____ to _____

Thank You,

_____
Signature of Patient

BALTIMORE
The Mead Building
315 N. Calvert Street
Baltimore, MD 21202

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

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

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