PAIN MANAGEMENT PHYSICIANS OF SOUTH FLORIDA, P.L

ANDREW J. GOLDBERG, M.D.

Authorization for Release of Medical Records

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

PLEASE RELEASE MY MEDICAL RECORDS TO:

Andrew J. Goldberg, M.D.
Pain Management Physicians of South Florida, PL
8880 Royal Palm Blvd. #103
Coral Springs, Fl 33065

Phone: (954) 975-8233
Fax: (954) 974-2335

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and all diagnostic tests.

BY MY SIGNATURE I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS

Patient: _____ Date: _____

Mailing Address: 8880 Royal Palm Blvd. Suite 103. Coral Springs, FL 33065
Office Address: 8880 Royal Palm Blvd. #103 Coral Springs, Florida 33065
Phone 954-975-8233 Fax 954-974-2335