Pain Management Physicians of South Florida, PL

Andrew J. Goldberg, M.D. Seth C. Wachsman, 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.
Seth C. Wachsman, M.D.
Pain Management Physicians of South Florida, PL

8880 Royal Palm Blvd. Suite 103. Coral Springs, Florida 33065

OFFICE NUMBER: (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: 5944 Coral Ridge Dr. # 190 Coral Springs, FL 33076