PAIN CARE SPECIALISTS OF FLORIDA
LUIS A. ESCOBAR, M.D.
DABPM. DAAPM, ABA

Pain Care Specialists of Florida

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, Date of Birth ____ / ____ / ____ , authorize release of my medical records to:

DR. LUIS ESCOBAR
Name of Hospital, Physician or Facility

4350 SHERIDAN STREET suite 102
Street Address

HOLLYWOOD FL. 33021
City **State** **Zip Code**

(954)322-8586 (954)322-8581
Phone # **Fax #**

Any medical information concerning my treatment, including psychological, psychiatric, drug abuse, alcoholism, AIDS, Aids testing and care of hospitalization which may be in your care.

_____ _____
Date **Patient Signature**