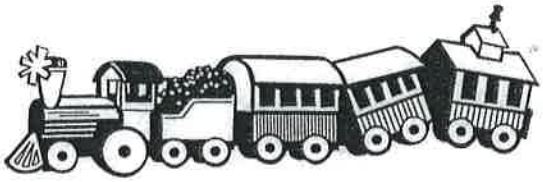

JUDE BARES, MD
PEDIATRICS & ADOLESCENT MEDICINE

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LAFAYETTE, LOUISIANA 70508
PHONE: (337) 988-2345
FAX: (337) 988-2353

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Use one form for multiple patients ONLY if all records are being transferred to the same place.

Today's date:_____

Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____

I, the parent/legal guardian of the above child, am approving the release of his/her medical records. I understand that the information contained in his/her records is confidential.
I hereby authorize and give my consent for:

referring Dr.

Name: _____ Phone: _____

Address: _____ Fax: _____
_____

Please check all that apply:

__Immunization Record
__Complete Medical Record
__Growth Chart
__Other: _____
_____

Release records to Dr. Bares at above mailing address or by fax.

_____ _____
Signature of Parent/Legal Guardian **Date**

Reason for Records Transfer:

__Moving Out of State
__Insurance Reasons
__Age of Patient
__Other Reason (please specify)
_____
_____
_____