



JOHN L. CLARK, M.D., F.A.A.P.
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1405 Metro Drive, Building L
Alexandria, LA 71301
(318) 767-1543
Fax (318) 767-1110

RELEASE OF MEDICAL RECORDS

Date: _____

To Dr. : _____

I hereby authorize you to release to:

JOHN L. CLARK, M.D., F.A.A.P.
ANN BUBENZER, M.D., F.A.A.P.
ZULMA N. LARACUENTE, M.D., F.A.A.P.
1405 Metro Drive, Building L
Alexandria, LA 71301

Any information of my child, including the diagnosis and records of any treatment or examination while under your care.

Child's Name : _____

Child's DOB : _____

Thank you,

Parent's Signature : _____