Richard W. Pratt, MD

Michael R. Melancon, MD

200 Liberty Avenue

Lafayette, LA 70508

Office: (337) 989-8080

Fax: (337) 981-0913

Consent for Medical Records

To: _____
(Name of doctor)

_____
(Phone number of doctor)

Patient Name and Date of Birth:

_____

To Whom It May Concern:

I hereby authorize Sola Pediatrics to examine any and/or all of my child's medical records, and to obtain Photostat copies of such records as they may desire; to discuss my child's medical history, examination, and treatment with physicians, nurses and other healthcare providers who have treated or examined my child.

I hereby waive the limitation and restrictions placed on disclosure of such information and records by Louisiana R. S. 13:3734 and release you from all legal liability that may arise from the release of the information requested. I further agree that authorization shall be valid and effective unless and until it is revoked by me in writing, and that a photocopy of this authorization may serve as an original.

Information requested: <u>All Patient Records</u>

Release to: Sola Pediatrics
200 Liberty Avenue
Lafayette, LA 70508

_____ _____
Parent / Legal Guardian Relationship to patient

_____ _____
Witness Date