Medical Records Release Form

Client Name (pet's legal owner / guardian): _____

Address: _____ City, ST, ZIP: _____

Home #: _____ Cell #: _____ Driver's License#: _____

Patient(s) Name: _____

I hereby authorize the release of medical health information from my pet's medical record:

From:	Office: _____	**To:**	Office: _____
	Address: _____		Address: _____
	City, ST, ZIP: _____		City, ST, ZIP: _____
	Phone: _____		Phone: _____
	Fax: _____		Fax: _____

Please release the following medical information from my pet's medical record:

_____ Entire Medical History
_____ X-Rays
_____ Lab Results
_____ All records pertaining to the latest health problem
_____ Other: _____

_____ **Please contact me when records are ready to be picked up at the hospital**
_____ **Please mail the records / xrays to the office noted above**
_____ **Please fax the records to the office noted above**

_____

Signature of Pet's Legal Owner / Guardian: _____

Date: _____