



Medical Records Release Form

CLIENT INFORMATION

Date _____

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ E-Mail Address _____

PATIENT INFORMATION

Name _____	Species _____
Name _____	Species _____
Name _____	Species _____
Name _____	Species _____
Name _____	Species _____

PLEASE INCLUDE COPIES OF (please circle)

Vaccine Records
Laboratory Reports
Exam Reports

Surgery Reports
Pathology/Biopsy
Reports

Radiology Reports &
Images
Entire Medical Record

RELEASE TO

Business Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ E-Mail Address _____

I hereby certify that I am the owner or authorized agent of the above-described pet(s). Further, I hereby request and authorize this veterinarian to release the requested medical information from my pet(s) to the above listed contact. I release the veterinarian and staff from any legal responsibility or liability for the release of information to the extent indicated as authorized herein.

I have read and understand the information in the form above _____
Signature