Request for Records Form

Name of person requesting records _____

Clinic Name _____

Address _____

City, State _____ ZIP Code _____

Phone _____ Fax _____

E-mail _____

Pet's Name _____

Pet Parent's Name _____

Pet Parent Phone _____

Pet Parent E-mail _____

Check the box(es) to specify the format in which you'd like the information to be released/obtained:

☐ E-mail (Preferred) ☐ Fax ☐ Mail (Pet Parent will be responsible for postage)

Check the box(es) to specify the information to be released/obtained. (At least one)

☐ Laboratory Results ☐ Radiographs

☐ Complete Medical Record ☐ Other (please specify)

Additional Comments:

_____
_____
_____
_____
_____

I hereby certify that I am the owner (Pet Parent) or authorized agent of the Pet Parent of the above-described pet(s). Further, I hereby request and authorize this veterinarian to release the requested medical information for my pet(s). I release the veterinarian and staff from any legal responsibility or liability for the release of information to the extent indicated as authorized herein. This authorization expires 90 days from the date of signature. I understand I may revoke this authorization, but the revocation may not be applied retroactively once the information specified herein has been released.

Signature _____ Date _____