AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Owner Name: ____

Address: ____

____

Phone: ____________________

Patient Name: ____

Breed: ____________ Age: _________

Sex: ____________ Color: _________

Information to be released (check applicable categories):

☐ Entire Medical Record ☐ Medical Records Dated From__________to__________

☐ Vaccination Record Only ☐ Laboratory Reports

☐ Radiographs/Ultrasounds ☐ Other: _____________________

Recipient Name: ____

Address: ____

____

Phone: ____________________

Owner Signature I request and authorize release of the medical information to the recipient as specified above.

Signature: _________________________ **Witness:** _________________

Date: _________________________ **Date:** _________________

Template folder/authorization for release of medical information

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