GENESEE VALLEY
EQUINE CLINIC

AUTHORIZATION FOR TREATMENT

<<< Submit by fax (585) 889-4635 or email gvec@gvequine.com >>>

OWNER NAME: _____
print name

OWNER ADDRESS: _____

OWNER PHONE: _____ EMAIL: _____

I request and authorize the release of the medical information to the recipient listed here, as specified below.

OWNER SIGNATURE: _____ DATE:

WITNESS SIGNATURE: _____ DATE:

During my leave from (date)_____ to _____,
I authorize (person) _____ to make decisions regarding
medical treatment for (horses names)_____.

He/She can be reached at the following number: (Cell/text) _____,
(second number)_____, (third number)_____

(*Circle one*) I do / do not authorize shipping the horse to a referral hospital for further treatment.

For transporting my horse, please contact: _____

During my absence, I can be reached at the following numbers: (cell 1)_____,
2nd number _____ (3rd number) _____

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Phone (585) 889-1170 · Email: gvec@gvequine.com · Fax (585) 889-4635