GENESEE VALLEY
EQUINE CLINIC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

OWNER 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: _____

EQUINE PATIENT NAME: _____ BREED: _____

AGE:_____ SEX: Stallion / Mare / Gelding COLOR:_____

INFORMATION TO BE RELEASED: (Check all that apply)

___ Entire Medical Record ____ Medical Records Dated from _____ to _____

___ Vaccination Records Only ____ Laboratory Reports

___ Radiographs / Ultrasounds ____ Other _____

RECIPIENT NAME: _____

RECIPIENT ADDRESS: _____

RECIPIENT PHONE: _____ EMAIL: _____

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