South Patrick
ANIMAL
HOSPITAL

Authorization to Release Veterinary Medical Records

Veterinary Hospital: _____

Veterinary Hospital Fax Number: _____

Owner Information:

Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Pet Information:

Pet Name: _____ Breed: _____

Pet Name: _____ Breed: _____

Pet Name: _____ Breed: _____

Pet Name: _____ Breed: _____

Please include copies of:

- ☐ Vaccination Records
- ☐ Fecal Test Records
- ☐ Heartworm Test Records
- ☐ Other: _____

I certify that I am the owner or authorized agent of the pet(s) listed above, and hereby request and authorize the above animal hospital to release the requested medical information for my pet(s) to South Patrick Animal Hospital.

Owner Name: _____

Owner Signature: _____ Date: _____

PLEASE FAX THE REQUESTED MEDICAL RECORDS TO SOUTH PATRICK ANIMAL HOSPITAL AT 321-773-8341 OR EMAIL TO SPANIMALHOSPITAL@GMAIL.COM AS SOON AS POSSIBLE.

THANK YOU.