Medical Records Request / Transfer to a New Vet

Please complete this form to authorize the release and transfer of your pet's medical records to a new veterinary practice.

Owner Information

- **Owner's Full Name:** _____
- **Phone Number:** _____
- **Email Address:** _____
- **Home Address:** _____

Pet Information

- **Pet's Name:** _____
- **Species:** ☐ Dog ☐ Cat ☐ Other: _____
- **Breed:** _____
- **Date of Birth / Approximate Age:** _____
- **Sex:** ☐ Male ☐ Female
- **Microchip Number (if applicable):** _____

Current Veterinary Practice

Practice Name: Oakwood Animal Hospital_____

New Veterinary Practice

- **Practice Name:** _____
- **Veterinarian's Name:** _____
- **Practice Address:** _____
- **Phone Number:** _____
- **Email Address for Records Transfer:** _____

Owner Authorization

I authorize **Oakwood Animal Hospital** to release and transfer my pet's veterinary medical records to the new veterinary practice identified above.

I understand that the records will be shared for the purpose of ensuring continuity of veterinary care.

- **Owner's Signature:** _____
- **Date:** _____

_____
_____

For Veterinary Practice Use Only

- **Date Request Received:** _____
- **Records Sent By:** _____
- **Date Records Transferred:** _____
- **Transferred To:** _____
- **Method of Transfer:** _____
- **Staff Initials:** _____

Send copies of all transfers to Manager