Medical Records Release Request

______________________________ ___________________
Client Name Patient Name

____ I request that copies or summaries of the medical records for the patient listed above be released to:

____
Practice Name

____
Street/ Mailing Address City, State & Zip

____
Fax Number

Reasons for release:____

____

____________________________ _____________
Signature of Owner Date

____________________________ _____________
Signature of Approving Veterinarian Date

* A $5.00 fee is required to photocopy and mail or fax this information as directed.