REQUEST FOR RELEASE OF MEDICAL RECORDS

FROM:_____

(Printed name of party requesting a copy of their animals medical records)

TO:_____

(Veterinary Clinic)

I request that copies of the medical records pertaining to my animal(s) named:

_____ _____

_____ _____

_____ _____

_____ _____

be released to the following veterinary practice, by fax:

Rose Veterinary Hospital

1910 High Street

Canon City, CO 81212

Fax Number of Recipient: 719.275.1179

I hereby authorize and provide my written consent to this transfer of medical information.

_____ _____

Signature of Owner or Authorized Agent Date