# The Cat Hospital Of Fairfax, Inc

## MEDICAL RECORDS RELEASE FORM

I hereby certify that I am the owner or authorized agent of the owner of the pet(s) described below. I, the undersigned do hereby request and grant my permission for the release of any or all of the information contained in the medical records pertaining to those pets listed below to named person, facility, or Veterinary Practice provided below:

**Client Name**: ________________________________________ **Account Number:**_______________

Client Address:______________________________________________________________________

Client Telephone Number(s):__________________________________________________________

Other Contact information (e.g. Email):_________________________________________________

**Pet Names** for Release of Medical Records:_____________________________________________

1.__________________________________________________________________________________

2.__________________________________________________________________________________

3.__________________________________________________________________________________

4.__________________________________________________________________________________

5.__________________________________________________________________________________

**Release Records to**:_______________________________________________________________

____________________________________________________________________________________

FAX/Address/Email/Hand Delivered: ____________________________________________________

This release will remain in effect until you notify us in writing of any desired changes.

I understand that Radiographs (X-rays) are the permanent legal property of The Cat Hospital of Fairfax, Inc., and originals must be returned within 30 days by Owner.

**Client Signature**:_____________________________________________________Date:___________

The Cat Hospital of Fairfax, Inc. Witness/Preparer: ________________________Date: __________

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