Jackson Veterinary Practice, PA

1925 A1A South St. Augustine,FL 32080
(904)471-3044

Authorization to Receive Records

To Whom It May Concern:

I, _____, authorize _____

to fax, mail or verbally give information including a full copy of medical records for my

pet(s) _____ to any employee of Jackson Veterinary

Practice, PA.

_____ _____

Client Signature Date

Please initial the appropriate line:

_____ I consent to a non-expiration date to this form unless I come in and request to end it.

_____ I wish to renew this form annually, therefore, it will expire one (1) year from the date above.