

Authorization to Release Veterinary Records

Pet Owner Information:

Name: _____

Address: _____

Telephone: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

Pet Information:

Name: _____ Breed: _____

Name: _____ Breed: _____

Name: _____ Breed: _____

The information to be released includes:

Entire Medical Record Vaccination History Only Current Vaccination Status only

Middletown Animal Clinic will provide the information requested above to the following:

Veterinarian Boarding Facility Training Facility

Grooming Facility Other (Please Specify): _____

Facility Name: _____ Telephone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

I hereby certify that I am the owner or authorized agent of the owner of the above described pet(s). Further, I hereby request and authorize Middletown Animal Clinic to release the requested medical information for my pet(s) to the above named facility. I release the Middletown Animal Clinic and their veterinarian and staff from any and all legal liability for the release of information to the extent indicated and authorize herein. This authorization information expires _____ days from the date of signature. I may revoke this authorization in writing at any time. The Middletown Animal Clinic policy is to provide the requested release within two (2) business days of the written request.

Owner or Owner's Agent Signature

Date