



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Owner Name: _____
Address: _____

Phone: _____

Patient Name: _____
Breed: _____ Age: _____
Sex: _____ Color: _____

Information to be released (check applicable categories):

- Entire Medical Record Medical Records Dated From _____ to _____
 Vaccination Record Only Laboratory Reports
 Radiographs/Ultrasounds Other: _____

Recipient Name: _____
Address: _____

Phone: _____

Owner Signature I request and authorize release of the medical information
to the recipient as specified above.

Signature: _____ **Witness:** _____
Date: _____ **Date:** _____

Template folder/authorization for release of medical information