Authorization to Release Veterinary Records

Records to be released are to be faxed or emailed to the stated recipient requested below as soon as possible:

Attn: ____
Fax: ____
Email: ____

Pet Parent Information:

Name:____
Address:____
City: ______________________ State: _________ Zip Code: _____________
Phone: ____

Pet Information:

Name: ____
Breed:____
Name: ____
Breed:____
Name: ____
Breed:____

Please include copies of (circle):

- Vaccination Records
- Laboratory Reports
- Exam
- Reports
- Surgery Reports
- Pathology
- Biopsy
- Reports
- Radiology
- X-Ray Reports
- Entire Medical Record

If specific dates are needed, please indicate, otherwise the entire medical record will be sent:
____

I hereby certify that I am the owner (Pet Parent) or authorized agent of the Pet Parent of the above described pet(s). Further, I hereby request and authorize this veterinarian to release the requested medical information for my pet(s) Millerton Veterinary Practice, PLLC. I release the veterinarian and staff from any legal responsibility or liability for the release of information to the extent indicated as authorized herein. This authorization expires 90 days from the date of signature. I understand I may revoke this authorization, but the revocation may not be applied retroactively once the information specified herein has been released.

PET PARENT SIGNATURE (client): _____________________________________ Date: ________________