Falls Road
ANIMAL HOSPITAL

Authorization for Veterinary Medical Records Release

In accordance with the Veterinary Practice Act regarding the confidentiality of patient medical records, a written authorization is required in order for Falls Road Animal Hospital to produce copies of your pet's medical records. Medical records released shall not contain any sensitive personal or financial information of the owner. Only medical treatment records shall be released.

CLIENT INFORMATION

Name:

Address: **Email:**

City: **State:** **Zip Code:** **Phone:**

PET INFORMATION

Name: **Breed:**

Name: **Breed:**

Name: **Breed:**

RELEASE PETS MEDICAL RECORDS TO

Name of Veterinary Practice/Boarding Facility:

Address: **Email:**

City: **State:** **Zip Code:** **Phone:**

FAX: **Attn:**

Other:

REASON FOR REQUEST

☐ **Relocation**
☐ **Second Opinion**
Primary Veterinary Copy
Other:
Referral to Specialist

Please include copies of:

☐ **Vaccination Records**
☐ **Pathology/Biopsy Reports**
☐ **Dental Radiographs (fee applies)**
☐ **Laboratory Reports**
☐ **Exam Results**
☐ **ICU Records**
☐ **Entire Medical Records from _____ to _____**
☐ **Radiology/X-ray Reports (fee applies)**

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 Falls Road Animal Hospital to release the requested medical information for my pet(s).

Signature of Owner _____ **Date** _____

For Staff Use Only

Patient files reviewed by Veterinarian:
Patient files were faxed on: *to:* *by:*
Patient files were mailed on: *to:* *by:*
Patient files were given to: *by:*