Request for Release of Medical Records

From: _____ (party requesting a copy of medical records)

To: _____ (practice name and address with patient records)

I request that copies or summaries, as required by state law, of the medical records pertaining to my animal(s) named _____ be released to the following veterinary practice or other party by fax or surface mail or by email:

_____

Name of Practice or Other Party

_____

Street Address City State Zip

Fax Number of Recipient _____ Email address of Recipient _____

Payment of $_____ is enclosed as payment of the fee required to photocopy and mail this information as directed. I hereby authorize and provide my written consent to this transfer of medical information.

_____ _____

Signature of Owner or Authorized Agent Date

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_____ _____

Signature of Veterinarian Who Approves This Request Date