Authorization to Release Veterinary Records

Pet Owner Information:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____ 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

Animal Medical Center of Middletown will provide the information requested above to the following: (please circle all that apply)

1) Veterinarian 2)Boarding Facility 3)Groomer 4) Trainer 5) Other

Name:_____ Telephone:_____

Address:_____Fax:_____

City:_____ State:_____ Zip Code:_____

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 Animal Medical Center of Middletown to release the requested medical information for my pet(s) to the above named facility. I release Animal Medical Center of Middletown, their veterinarians and staff from any and all legal liability for the release of information to the extent indicated and authorized herein. I may revoke this authorization in writing at any time. The Animal Medical Center of Middletown policy is to provide the requested release within two (2) business days of the written request.

Owner or Agent's Signature:_____

Date:_____