



PET PARENT INFORMATION:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Clients e-mail address _____ Phone: _____

Pet Information:

Name: _____ Breed: _____

Name: _____ Breed: _____

Name: _____ Breed: _____

Please include copies of:

Vaccination Records Laboratory Reports Exam Reports Surgery Reports Radiographs/Imaging

*****Attention Please*****

Please keep in mind, we will only provide records for up to 3 years. If additional information is requested by the new hospital, there will be a record preparation fee. Please be advised it may take up to 3-5 business days to e-mail your medical records once our hospital receives your request.

Radiographs/imaging requests will be e-mailed directly to your new doctor and at the doctor's discretion. This process could take up to 7-10 days.

Hospital Name: _____ Hospital Phone #: _____

Hospital E-mail Address: _____

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 (pets) to the above listed contact. I release the veterinarian and staff for any legal responsibility or liability for the release of information to the extent indicated as authorized herein.

PET PARENT SIGNATURE: _____ Date: _____